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IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1979

No._____

ELVINA M. HERWEG, by her husband and next friend, Darrell E. Herweg; and DARRELL E. HERWEG, on behalf of themselves and all others similarly situated,

Petitioners,

vs.

ROBERT D. RAY, individually and in his capacity as Governor of the State of Iowa; and KEVIN J. BURNS, individually and in his capacity as Commissioner of the Iowa Department of Social Services,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

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QUESTION PRESENTED

Whether the Court of Appeals' invalidation of a regulation promulgated by the Department of Health and Human Services which was designed

to ensure that, in the so-called "SSI states," Medicaid applicants and recipients would have the eligibility conditions and rules of the Supplemental Security Income ("SSI") program applied to them was appropriate in light of the explicit requirements of the Medicaid and SSI statutes and the deference due the responsible federal agency.

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OPINIONS BELOW

The opinion of the Court of Appeals, which is not yet reported, appears as Appendix "A". The district court Memorandum Opinion and Order of January 19, 1978, reported at 443 F.Supp. 1315, and the district court's Ruling and Order of July 10, 1978, reported at 481 F.Supp. 914, are attached as Appendices "B" and "C", respectively. The Final Judgment of August 4, 1978 appears as Appendix "D".

JURISDICTION

The Court of Appeals, en banc, filed its order and judgment on March 18, 1980. On April 22, 1980, a timely petition for rehearing was denied (Appendix "E"). This petition for certiorari is being filed within 90 days of the denial of the petition for rehearing. This Court's jurisdiction is invoked under 28 U.S.C. §1254(1).

STATUTES AND REGULATIONS

The following statutes and regulations relevant to the consideration of this petition are set out verbatim in Appendix "F":

42 U.S.C. §1396a(a)(10)
42 U.S.C. §1396a(a)(17)
42 U.S.C. §1396a(f)
42 C.F.R. §435.723

STATEMENT OF THE CASE

1. The Medical Assistance program, commonly known as Medicaid,

> "is a cooperative federal-state program established in 1965, in Title XIX of the Social Security Act . . . , 42 U.S.C. §1396, et seq. The basic purpose of Medicaid is to enable each state, as far as practicable under the conditions in each state, to furnish medical assistance to certain needy persons whose income and resources are insufficient to meet the costs of necessary medical services. 42 U.S.C. §1396; e.g., Beal v. Doe, 432 U.S. 438, 444 (1977); Hodgson v. Board of County Commissioners, [614 F.2d 601, 606 n.8 (8th Cir. 1980)] . . . . The Medicaid program is jointly financed by the federal and state governments and administered

by the states." Herweg v. Ray, No. 78-1664 Sl.Op., at 24 (8th Cir., March 18, 1980) (McMillian, J., concurring in part, dissenting in part); (App. "A", at 34a); see also, e.g., Preterm, Inc. v. Dukakis, 591 F.2d 121, 124 (1st Cir.), cert. denied 441 U.S. 592 (1979); Fabula v. Buck, 598 F.2d 869 (4th Cir. 1979). [1/]

Although a state is not required to participate in Medicaid, it is encouraged to join by the reimbursement it receives from the federal government. In Iowa's case, this amounts to 56.57% of the costs incurred. 42 U.S.C. §1396b; 44 Fed.Reg. 10553 (Feb. 21, 1979). In order to participate, the state must submit a "state plan" to the Secretary of the Department of Health and Human Services (formerly "HEW" and hereinafter "HHS") which describes the nature and scope of its planned Medicaid program. 42 U.S.C. §1396a. The state is supposed to meet the requirements of federal law in order to be reimbursed for its expenditures. 42 U.S.C. §§1396a(b), 1396b; McM.Op. at 24-25 (App. "A", at 34a-35a). See also, e.g., Fabula v. Buck, supra, 598 F.2d, at 870-871. In practice, though, as

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1/ The eight members of the court split evenly on the issue presented to this Court. For convenience, therefore, petitioners will hereinafter refer to the decision which resulted in affirmance of the district court, authored by Judge Ross, as the "Ross Op.," while that written by Judge McMillian will henceforth be termed the "McM.Op."

the sole sanction available to the Secretary of HHS is the cessation of payments to the state, 42 U.S.C. §1396c, HHS undertakes a seemingly endless process to curb improper state rules and allows the illegal practice to continue during the process, as it did in this instance. See generally Rosado v. Wyman, 397 U.S. 397, 405 n.8 (1970).

A key element of the federal Medicaid scheme is the flexibility which it allows the states. Thus, although a state must operate within the guidelines established by federal statute and regulations, it has numerous options available to it in establishing the contours of its program. The state must provide assistance to the so-called "categorically needy," but the precise delineation of that group is left to the discretion of the state. Compare 42 U.S.C. §1396a(a)(10)(A) with 42 U.S.C. §1396a(f); see McM.Op., at 33-38 (App. A, at 45a-51a); see generally Beal v. Doe, supra, 432 U.S., at 440 and n.1; Friedman v. Berger, 547 F.2d 724 (2d Cir. 1976), cert. denied 430 U.S. 984 (1977); Norman v. St. Clair, 610 F.2d 1228, 1230-1231 (5th Cir. 1980). In general terms, the categorically needy are those who meet the categorical definitions of being aged, blind, disabled, or dependent children, and who have income and resources below certain levels. Furthermore, a state may provide a program for the so-called "medically needy," 42 U.S.C. §1396a(a)(10)(C), who are those meeting the categorical definitions but with income or resources above the categorically needy levels. See, e.g., Norman v. St. Clair, supra, 610 F.2d, at 1231. Also, a state may provide categorically needy coverage to certain optional groups, such as some institutionalized individuals, who are not

actually receiving cash assistance and would therefore otherwise be ineligible as categorically needy. 42 U.S.C. §1396a(a)(10)(C)(III). See generally McM. Op., at 39-40 (App. A, at 52a-53a).

Iowa elected not to cover the medically needy, but it did include coverage for certain of the optional categorical groups. It also decided not to be a so-called "209(b) state" pursuant to 42 U.S.C. §1396a(f), which would have allowed it to use eligibility conditions for the categorically needy more restrictive than those used in the Supplemental Security Income ("SSI") program, 42 U.S.C. §§1381, et seq., Title XVI of the Social Security Act, but no more restrictive than those in effect in a state's program on January 1, 1972. By thus becoming an "SSI state," Iowa, like about two-thirds of the states, has elected to tie Medicaid eligibility for the categorically needy aged, blind, and disabled to the SSI statute. 2/

2/ At present, fifty-three jurisdictions have Medicaid programs. Arizona is the only state without one. Fifteen states have selected the "209(b) option," while thirty-four states and the District of Columbia are "SSI states." SSI does not apply to Guam, Puerto Rico, and the Virgin Islands, and Medicaid eligibility is there based on the old state-administered categorical assistance programs for the aged, blind, and disabled. See 42 C.F.R., Part 436.

In December, 1975, HHS proposed amended regulations which were intended to specify explicitly the relationship between SSI and Medicaid for purposes of calculating income and resources in determining Medicaid eligibility and amount of assistance. 40 Fed. Reg. 60074 (Dec. 31, 1975). These proposed regulations were offered nearly two years after the SSI statute went into effect and after states were given the option of tying Medicaid eligibility to SSI eligibility or of using their more restrictive prior rules. These proposed new regulations, then to be codified in relevant part at 45 C.F.R. §248.3(b), were intended to replace the regulations which were based exclusively on the language of the Medicaid statute and which did not draw any connection between Medicaid and SSI eligiblity. See 40 Fed. Reg. 60074, column 2, note 4. Like other interested parties, the states were given the opportunity to comment on these proposed regulations. 40 Fed. Reg. 60074.

More than a year after their publication, the proposed regulations, in revised form, were re-published, with an effective date of April 13, 1977. 42 Fed. Reg. 2684, et seq. (Jan. 13, 1977). As is customary, HHS included with the new regulations a synopsis of the comments which had been received and an explanation as to why these new regulations were required. In brief, it was the relationship between SSI and Medicaid, and the need to ensure that all SSI-eligibles in the "SSI states" would be automatically eligible for Medicaid, which HHS saw as the determinative factor in the promulgation of these new regulations. See id., at 2685.

The proposed new regulations, which were ultimately published in their present form at 42 C.F.R. §435.723,[3] controlled the procedure generally known as "deeming." Under this process, income or resources could be considered available to an individual whether in fact they were actually available; the term "deeming" was used because the assets were deemed available. The then-new regulations specifically forbid "SSI states" from deeming the income and resources of a non-institutionalized spouse available to an institutionalized spouse after either the calendar month of institutionalization or after six months of institutionalization, depending on the eligibility status of the non-institutionalized spouse.[4] Tracking the relevant portions of the SSI statute, the regulations effectively required the state to treat the spouses as separate economic

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[3] 45 C.F.R. §248.3(b) was redesignated as 42 C.F.R. §448.3(b). 42 Fed. Reg. 52827 (Sept. 30, 1977). A year later, HEW rewrote - but with no "policy changes" - and redesignated its Medicaid regulations. See 43 Fed. Reg. 45176, et seq. (Sept. 29, 1978). The relevant parts of 42 C.F.R. §448.3(b) became 42 C.F.R. §435.723. See Norman v. St. Clair, supra, 610 F.2d, at 1235 n.12; Gray Panthers v. Secretary, Dept. of H.E.W., 461 F.Supp. 319, 320 n.2 (D.D.C. 1978), appeal pending No. 79-1334 (D.C. Cir., argued Jan. 15, 1980).

[4] Compare 42 C.F.R. §435.723(c) with 435.723(d).

units after the one- or six-month period of institutionalization had passed.

Iowa explicitly balked at employing these rules. The Iowa General Assembly instructed the state Department of Social Services to "resist the implementation" of these regulations. House File 464, section 18, Acts of the 67th General Assembly. The Department complied by issuing its Manual Letter No. XXI-1-28 (part 2) on June 3, 1977. Herweg v. Ray, No. 77-22-1, App. "B", at 76a (443 F.Supp., at 1316-1317). Under this directive, a portion of the income of the non-institutionalized spouse, computed by use of an arbitrary formula which did not take into account the individual needs and expenses of that spouse, was assumed available to the institutionalized spouse, regardless of whether the deemed amount accurately reflected the financial situation of the non-institutionalized spouse and regardless of whether in fact the non-institutionalized spouse made the contribution.

Iowa resisted HHS' compliance efforts. In a letter to the HHS regional commissioner in Kansas City on June 15, 1977, defendant Burns defended Iowa's decisions on the grounds that "[w]e have determined that the revised regulations . . . are not in the best interest of the state or its citizens." Appendix to Brief of Appellants, filed below, at 36. Thus, from the date of the implementation of the regulations at issue, April 13, 1977, the state of Iowa has been explicitly, directly, and intentionally in violation of those regulations.

2. Plaintiffs Elvina and Darrell Herweg were married on July 30, 1949.[5/] Elvina Herweg has been in a comatose state since suffering aneurisms and cerebral hemorrhages on both sides of her head in August, 1976. She was placed in a long-term care facility on November 1, 1976.

The rest of her family, consisting of her husband, Darrell, and their three teenage daughters, continued to live at their home in Council Bluffs, Iowa. Mr. Herweg was employed as a butcher, and had a net take-home pay of $1,032 per month at that time. He applied for Medicaid for his wife in January, 1977, and after an initial determination of eligibility, his monthly contribution (i.e., the deemed amount) was set at $234.80.

Using the procedure for calculating available income set out in Manual Letter No. XXI-1-28, though, the Department of Social Services issued a Notice of Decision on June 2, 1977 informing them that because of a higher deemed amount, she would be ineligible for assistance effective June 30, 1977. That decision was affirmed on July 21, 1977. Since the approximate monthly cost of her care was then $1,374, and he obviously could not afford this amount, they brought this action. App. "B", at 78a (443 F.Supp., at 1316-1317).

[5/] The details of their situation, including the financial aspects, are set out in the district court decision, App. "B", at 77a-78a (443 F.Supp., at 1316-1317).

3. This class action was filed in district court on July 28, 1977 with the causes brought under 42 U.S.C. §1983 and jurisdiction alleged under 28 U.S.C. §§1343(3), (4), and 1331.[6/] On that same date, Chief Judge Stuart granted the request for a temporary restraining order. On August 11, 1977, the Iowa Department of Social Services issued a new "Proposed Decision" which modified the formula calculations; under the new determination, she was eligible, but $150.30 of his monthly income was still to be deemed to her. If he failed to make the payment, "eviction would be imminent." App. "B", at 78a-79a (443 F.Supp., at 1317).

The plaintiffs filed an amended complaint on September 15, 1977, elaborating on their arguments against the state's deeming policy. After the parties stipulated to the material facts, the district court issued its initial decision on January 19, 1978. The court held that the Medicaid statute precluded the use of an arbitrary formula in determining the amount to be deemed, and that an individualized factual determination had to be made in each case. App. "B", at 83a-84a (443 F.Supp., at 1319, 1320). It held further that the state "procedures are also contrary to

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6/ The district court found jurisdiction proper under all of those sections, App. "B", at 77a (443 F.Supp., at 1316), and the Court of Appeals saw the district court's jurisdiction as proper under §1343(3). Ross Op., at 6 (App. "A", at 10a).

[the federal] regulations which arbitrarily refuse to impute the income of a non-institutionalized spouse to defray expenses of an institutionalized spouse." App. "B", at 86a (443 F.Supp., at 1320). The court expressed doubt, though, as to the propriety of the federal regulations, but it refused to reject them outright because "[the Secretary and HHS] are not represented in this action and it is therefore not appropriate to make a finding on the validity of that section." App. "B", at 87a (443 F.Supp., at 1320). The district court certified the requested class and issued a permanent injunction "against state 'deeming' procedures." App. "B", at 87a-88a (443 F.Supp., at 1320).

Because of the parties' uncertainty as to the precise meaning of the decision and its implementation, they returned to the district court for further elaboration. The court issued a second Ruling and Order on July 10, 1978. App. "C" (481 F.Supp. 914). In that Order, Judge Stuart agreed with plaintiffs that "anti-alienation" provisions forbade consideration of the Social Security, Civil Service, and Railroad Retirement benefits of a non-institutionalized spouse, and therefore required that they be disregarded in computing income of the non-institutionalized spouse. Furthermore, he agreed in principle to the notice prepared by plaintiffs by which members of the class would be informed of their potential eligibility for reimbursement of the amounts illegally deemed from them since the filing of the complaint. And, finally, he elaborated on his previous discussion of the propriety of deeming, concluding, in effect, that

as long as an arbitrary formula was not employed, the state was permitted to deem a contribution available from the non-institutionalized spouse. App. "C", at 92a (481 F.Supp., at 916-917). He did not further discuss the applicable federal regulations.

Judge Stuart summarized and incorporated his two decisions into a Final Judgment and Final Order which was filed on August 4, 1978. Plaintiffs timely appealed to the Eighth Circuit, contending that federal law did not permit a state to assume or deem any income or resources available, regardless of whether an individualized determination was used to compute the "reasonable" contribution of the non-institutionalized spouse. The defendants did not appeal any aspect of the district court's orders and decisions.

The appeal was initially argued before a three-judge panel of the Court of Appeals on January 12, 1979.[7/] No decision ever issued from that panel; submission of the appeal was vacated on August 10, 1979 by the Court sua sponte. It was set for re-argument en banc on September 10, 1979. In addition, by letter, the court asked the then-Department of Health, Education and Welfare to submit a brief amicus curiae "specifically" directed at the validity of "the regulation at issue (42 C.F.R. §435.723(d))

7/ The members of the panel were Circuit Judges Ross and McMillian, and District Judge Van Sickle, sitting by designation.

. . . ." The brief submitted by HHS was its first and sole participation in this case. It was not asked to participate in oral argument.

In the Court of Appeals' order and decision of March 18, 1980, the district court's judgment on the propriety of deeming was "affirmed by an equally divided court. . . ." 8/ Although Judge Ross recognized that the district court had not "specifically rul[ed] on the validity of the [federal] regulation," Ross Op., at 4 (App. "A", at 6a), he also noted that "there is no dispute that the new [state] procedure approved by the district court is contrary to regulation, §435.723." Id., at 7 (App. "A", at 10a-11a). And Judge McMillian's opinion also assumed that the issue before the court was the propriety of the federal regulation. Thus, both sides of the Court of Appeals directed their attention primarily at a determination of whether the controlling federal regulation, 42 C.F.R. §435.723, was valid. This approach was undertaken despite the fact that the institution responsible for the regulation, HHS, was not a party to the action.

8/ Curiously, all eight members of the Court reversed the district court's decision forbidding consideration of government benefits because of the applicable "anti-alienation" provisions. Ross Op., at 19-20, McM. Op., at 56-57 (App. "A", at 28a, 74a). This action was peculiar since the defendants had not appealed that decision, nor had either party or HHS discussed that issue in their briefs to the Court of Appeals or at either oral argument.

Judge Ross views the applicable consideration as "whether the regulation is an incorrect interpretation of the statute [42 U.S.C.] §1396a(a)(17). . . ." Ross Op., at 7 (App. "A", at 11a). By contrast, Judge McMillian finds the question to be "whether the regulation is proper, not how the statutory term should be interpreted," and "whether the federal regulation itself is a reasonable interpretation of the statutory provision." McM. Op., at 22, 23 (App. "A", at 32a, 33a)(emphasis in original). Judge McMillian thus places considerably greater reliance on the interpretation of the Secretary, especially in light of the specific statutory provision directing the Secretary to prescribe the appropriate standards. 42 U.S.C. §1396a(a)(17)(B). McM. Op., at 23 (App. "A", at 32a). In any event, Judge McMillian, regardless of which standard is employed, concludes that the federal regulation is the more appropriate interpretation of the statute. McM. Op., at 23 (App. "A", at 33a).

The two opinions are also noteworthy because of the different approaches to the substantive issue which they employ. Judge Ross devotes his attention primarily to the Medicaid statute itself, especially 42 U.S.C. §1396a(a)(17). His reasoning depends on the impropriety, in his view, of HHS reading the "availability" language of 42 U.S.C. §1396a(a)(17) to mean "actually contributed." Ross Op., at 11 (App. "A", at 17a-18a). Furthermore, he notes that HHS "does not cite any SSI statute that dictates the 'actually contributed' language of the Medicaid regulation, 435.723." Id., at 14 (App. "A", at 22a) (emphasis in original). He refuses to accept the

connection between the SSI and Medicaid statutes, preferring to find the resolution of the question solely in section 1396a(a)(17). Id., at 15 (App. "A", at 23a. Finally, Judge Ross evidences considerable concern with the perceived fiscal effect of the federal regulations on states and taxpayers and with the alleged incentive which the federal regulations provide to non-instutitionalized spouses to ignore their responsibilities. Id., at 18, 21 (App. "A", at 26a-27a, 29a).

Judge McMillian, however, recognizes the pivotal link between the SSI statute and the Medicaid statute: "[T]he deeming regulation is based upon SSI eligibility criteria and is mandated by the Medicaid statute itself, which defines Medicaid eligibility by referring to SSI eligibility." McM.Op., at 26 (App. "A", at 37a). He notes that integration of the SSI rules into the Medicaid situation is implicitly contemplated by the Medicaid statute's legislative history, and that the recognition of financial responsibility in 42 U.S.C. §1396a(a)(17)(D) is not repudiated by the HHS regulation, but is, rather, limited by it. Id., at 29-31 (App. "A", at 40a-42a). Judge McMillian analyzes in detail both the history of the Medicaid statute and the creation of the SSI program, and he evaluates the "link" between the two set out in 42 U.S.C. §1396a(a)(10)(A). He determines that the SSI rules on separation of spouses must be applied, and have been applied, by the comparable Medicaid regulations. Id., at 46-47 (App. "A", at 61a-62a). He brings together the different statutes and provisions by recognizing what Congress intended and what HHS has implemented: "In sum, Medicaid eligibility in

an SSI state is premised upon SSI eligibility." Id., at 49 (App. "A", at 65a).

The split decision of the Court of Appeals results in the affirmance of the district court despite the specific federal regulation mandating a contrary result. The effect is the invalidation of the federal regulation.

REASONS FOR GRANTING THE WRIT

THE EIGHTH CIRCUIT'S DECISION CONTRADICTS EXPLICIT CONGRESSIONAL INTENT, THE REASONABLE EFFORT OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO EFFECT THAT INTENT, AND NUMEROUS FEDERAL COURTS WHICH HAVE CONSIDERED THE MEDICAID-SSI RELATIONSHIP

The regulation which the Court of Appeals has invalidated, 42 C.F.R. §435.723, represents the determination by HHS as to the limitations on "deeming" which must exist under the Medicaid and SSI statutes in the so-called "SSI states." That the specific issue of "deeming" is itself an important one is readily apparent from the number of cases which have dealt with it.[9/]

[9/] See, e.g., the list of cases in Judge Ross' opinion, at 7-8 n.3 (App. "A", at 11a-13a n.3); see also Norman v. St. Clair, supra, 610 F.2d, at 1240 n.16.

Indeed, one state has now suggested that a conflict exists between the circuits on an aspect of the deeming issue in the "209(b) states." Brown v. Stanton, 617 F.2d 1224 (7th Cir. 1980), pet. for cert. filed No. 79-1690, 48 U.S.L.W. 3735 (April 25, 1980). But those cases, and other similar ones pending,[10/] are directed at a different issue -- a considerably more limited issue.

Their concern is with the issue of Medicaid deeming in the fifteen "209(b) states." The instant case, however, deals not only with the issue of Medicaid deeming in the remaining "SSI states," but, in addition, is concerned with perhaps the most important aspect of Medicaid eligibility. That aspect, the subject of this petition, is whether the eligibility conditions of the SSI statute necessarily apply to determinations of Medicaid eligibility for the aged, blind and disabled in those 35 jurisdictions. If the Eighth Circuit decision is allowed to stand, all prior assumptions as to the integration of Medicaid and SSI eligibility conditions will be undermined. Indeed, the decisions of virtually every court which has considered the issue will be suspect. Given the chaotic results which the Court of

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10/ Allen v. Califano, No. C-78-0212 (D. Utah, Aug. 22, 1979), appeal pending No. 79-2167 (10th Cir.); Gray Panthers v. Secretary, Dept. of H.E.W., 461 F.Supp. 319 (D.D.C. 1978), appeal pending No. 79-1334 (D.C. Cir., argued Jan. 15, 1980).

Appeals' decision could engender, it is imperative that that decision be explicitly overruled. Otherwise, other states, like Iowa, will act with impunity towards those Medicaid regulations with which they disagree. This case, therefore, has implications well beyond the issue of deeming; as significant as that issue itself may be, a considerably more important one is raised by the Eighth Circuit's resolution of this case.

The critical issue in this case, unlike in the 209(b) deeming cases, is not the appropriate interpretation of "availability," but the proper evaluation of the integration of the two statutes. Congress specifically left it to the Secretary to define "availability." 42 U.S.C. §1396a(a)(17)(B). While that task may occasion a complex analysis for the 209(b) states, the interpretation in this context is controlled by another provision of the statute, 42 U.S.C. §1396a(a)(10), which leads directly to only one result. As Judge McMillian notes: "[T]he deeming regulation is based upon SSI eligibility criteria and is mandated by the Medicaid statute itself, which defines Medicaid eligibility by referring to SSI eligibility." McM.Op., at 26 (App. "A", at 37a)(emphasis supplied).

The mandate and reference to the SSI eligibility criteria appears in §1396a(a)(10). The impact of that section is to require that all SSI eligibles be eligible for and receive Medicaid. The provision states that:

> "A State plan for medical assistance must -- . . . (10) provide -- (A) for

> making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI . . . or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter. . . ." 42 U.S.C. §1396a(a)(10)(A).

The controlling provision, therefore, twice notes the connection between SSI eligibility and Medicaid eligibility.

Congress' intent with this section should be obvious. Because of the Eighth Circuit's deviation, however, it is necessary to conclusively demonstrate that the courts and HHS have consistently understood this section to require that all SSI eligibles be eligible for and receive Medicaid. In a number of cases discussing various aspects of the relationship between SSI and Medicaid, the impact of SSI eligibility on Medicaid eligibility has been repeatedly spelled out. Those cases indicate the degree of the Eighth Circuit's departure from the universally accepted interpretation of the law. Caldwell v. Blum, ___ F. 2d ___, CCH Medicare & Medicaid Guide, par. 30,452 (2d Cir. 1980),[11] stay denied No. A946,

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[11] Congress "amended §1396a(a)(10) to state expressly (as it does now) that states must provide medical assistance to SSI recipients. Pub. L. No. 93-233, §13 (1973)." CCH Medicare & Medicaid Guide, par. 30,453, at 9759.

___ U.S. ___, 100 S.Ct. 1635 (1980) (Marshall, J.),[12] stay again denied, ___ U.S. ___, 48 U.S.L.W. 3785 (June 2, 1980) (en banc); Norman v. St. Clair, supra; Fabula v. Buck, supra;[13] Friedman v. Berger, 547 F.2d 724 (2d Cir. 1976), cert. denied 430 U.S. 984 (1977);[14] Hayes v. Stanton, 512 F.2d 133 (7th Cir. 1975); Gray Panthers v. Dept. of H.E.W., supra;[15]

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[12] "Any State which participates in Medicaid must extend medical benefits to all persons receiving supplemental security income (S.S.I.) benefits. . . . Such persons are known as the 'categorically needy.'" 100 S.Ct., at 1636.

[13] "[T]he Social Security Act requires that all SSI recipients be included in the state's Medicaid program and the transfers [of assets] could not affect SSI eligibility." 598 F.2d, at 874 n.13.

[14] "Aged, blind, and disabled patients whose personal incomes are low enough to qualify under the SSI program are considered 'categorically needy' and must be included within any state plan, 42 U.S.C. §1396a(a)(10)(A)." 547 F.2d, at 726 (footnote omitted).

[15] "The thirty-four states and the District of Columbia which automatically provide Medicaid assistance to recipients of Supplemental Security Income ['SSI'] are now specifically required to use the SSI rule on availability of income." 461 F.Supp., at 321.

Manfredi v. Maher, 435 F.Supp. 1106 (D. Conn. 1977);[16] West v. Cole, 390 F.Supp. 91 (N.D. Miss. 1975).[17]

Indeed, the very purpose of the "209(b)" option, which is codified at 42 U.S.C. §1396a(f), was to provide states with an opportunity to avoid the requirement that all SSI eligibles automatically be eligible for Medicaid. Congress was concerned that by forcing states to cover all SSI eligibles, their Medicaid roles might be increased so extensively that some states would decide not to participate in Medicaid at all. See Norman v. St. Clair, supra, 610 F.2d, at 1235; Hayes v. Stanton, supra, 512 F.2d, at 137-138; Gray Panthers v. Secretary, Dept. of H.E.W., supra, 461 F.Supp., at 321; West v. Cole, supra, 390 F.Supp., at 98-99 and nn. 5, 6. Thus, the legislature provided a method to avoid the strict

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16/ "In 35 of the 50 states, the issues before the Court could be resolved by a simple reference to extant regulations and case law authorities. In such states, Medicaid eligibility is linked directly to the criteria used in determining eligibility for the underlying categorical assistance programs. . . ." 435 F.Supp, at 1112.

17/ "Congress amended the Medicaid Act at 42 U.S.C. §1396a(a)(10) to expressly require all states to provide Medicaid assistance to all SSI beneficiaries." 390 F.Supp., at 98.

requirement that all SSI eligibles be covered. But Iowa did not take that option.

Not surprisingly, therefore, HHS saw its task after the passage of SSI as insuring that the SSI rules were imposed on the SSI states for Medicaid eligibility determinations. Thus, when it first proposed the regulations which became those here invalidated, HHS noted that its purpose was to set "forth the rule for use of SSI policy in determining the availability of the income and resources of spouses and parents for aged, blind, and disabled applicants in States using title XVI eligibility criteria." 40 Fed. Reg. 60074, 2d col. (Dec. 31, 1975). That was all the agency was ever attempting to do. Later, when the final regulations were published, it noted:

> "The new regulations require States to use title XVI availability criteria where Medicaid is provided to all supplemental security income recipients, as is already called for in section 1902(a)(10) of the Act." 43 Fed. Reg. 2685, 1st col. (Jan. 13, 1977)(emphasis supplied).

In short, HHS was only trying to set out in detail what was already called for in the statute.

It should, therefore, be indisputable that an SSI cash recipient must have the SSI eligibility conditions applied to her in determining Medicaid eligibility. In addition, there are individuals who are SSI eligible and therefore categorically needy, but who do not actually receive SSI cash benefits. Many nursing

home residents are in this category, for the SSI cash assistance level for the institutionalized is only $25 per month. 42 U.S.C. §1382(e)(1)(B); see McM.Op., at 47-48 (App. "A", at 63a). In order to ensure, however, that this low level would not preclude them from obtaining necessary Medicaid coverage, Congress extended categorical coverage to the aged, blind, and disabled beyond those who actually receive cash assistance. 42 U.S.C. §1396a(a)(10)(C)(III); 42 C.F.R. §§435.211, 435.231. This was accomplished by allowing states to set a higher SSI eligibility level of up to 300% of the normal SSI level. 42 U.S.C. §1396b(f)(4)(C). As Judge McMillian described it: "[T]he use of a higher income level for institutionalized individuals is based upon a fictitious optional state supplement where no benefits are actually paid or received by the institutionalized individual." McM.Op., at 49 (App. "A", at 65a).[18] Thus, individuals who would

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[18] This extension of coverage to the instututionalized was part of a larger effort to include certain people whose Medicaid eligibility Congress sought to encourage, but did not wish to mandate. Thus, those individuals not eligible for federal SSI benefits, but to whom states were encouraged to provide optional state supplement benefits because of the savings which states accrued by the federal government's take-over of the welfare program for the aged, blind and disabled, provided the theoretical basis for the creation of the "optional categorically needy." See 42 U.S.C. §1382e; 42 C.F.R. §435.230; see McM.Op., at 36-37 (App. A, at 49a-50a). Congress built on this extension of categorically needy coverage to create other optional groups, such as the institutionalized.

otherwise have not been eligible for Medicaid are classified with other SSI eligibles. As the decision below points out, Iowa took this limited option (as opposed to the broader and more expensive coverage of a medically needy program), and was using a $600 per month SSI level for institutionalized people as of July 1, 1979. McM. Op., at 49 (App. "A", at 65a). 19/

The creation of the optional categorically needy represented an effort to allow states to provide Medicaid to institutionalized people and others who would otherwise not have been eligible while at the same time not forcing states to develop a medically needy program in order to include these individuals.

> "This Committee bill therefore allows a State to deem an institutionalized person in need of a supplementary payment if his income is within 300 per cent of the SSI benefit level applicable to a non-institutionalized individual with no other income. . . . This [300%] limitation would be the same nationwide, and so would treat all States equitably, would allow most nursing home recipients to be covered,

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19/ Mrs. Herweg herself was, or should have been, SSI eligible as a cash assistance recipient, since her lack of any income whatsoever placed her below the $25 per month level for SSI cash assistance. McM. Op., at 56 (App. "A", at 73a).

and yet would assure that nursing home patients would be reasonably in need when compared to other Medicaid eligibles. . . ." S. Rep. No. 93-553, 93d Cong., 1st Sess. (1973), at 58.

The purpose of the optional groups indicates that they are to be considered like any other categorical group. Section (10)(A) itself applies to those "receiving aid or assistance under any plan of the State approved under subchapter XVI," and is thus not limited only to those actually receiving cash benefits. Moreover, the structure of the optional categorically needy indicates that Congress viewed then as an offshoot of the cash-assistance categorically needy, and subject to no different conditions. Congress was attempting to secure for the optional categorically needy the same rights as cash recipients had. As Judge McMillian recognized: "[T]he classification 'optional categorically needy' allows the states to selectively extend Medicaid coverage to individuals who are otherwise eligible to receive cash assistance but [are] not actual recipients." McM. Op., at 39 (App. "A", at 53a)(emphasis in original).[20/]

[20/] Further recognition of the non-cash recipient SSI eligibles as categorically needy is provided in 42 U.S.C. §1396a(a)(14). That section explicitly lumps the non-cash recipients in with the cash recipients in paragraph (A), thus precluding imposition of the co-payment on these individuals, while also explicitly indicating in paragraph (B) that the non-cash recipient SSI eligibles are not to be included with the medically needy on whom co-payments can be imposed.

In any event, subsection (10)(C) ensures that no more restrictive eligibility conditions are applied to any optional coverage group than are applied to those mandatorily covered. As HHS noted in the comments to these regulations:

> "[Section (10)(C)(i)] means that while a State might use more generous maintenance amounts in determining financial eligibility (i.e., medically needy levels, optional State supplementary payment levels, disregards or asset exemptions), all other SSI eligibility criteria are to be used." 42 Fed. Reg. 2685, 1st col. (Jan. 13, 1977).

Indeed, every court but one has agreed that the medically needy cannot have more restrictive eligibility conditions applied to them than are applied to the categorically needy.[21/] It would be illogical and inequitable to require the same eligibility conditions for the cash recipient categorically needy and the medically needy, while allowing more restrictive conditions for the

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21/ See, e.g., Caldwell v. Blum, supra, CCH Medicare & Medicaid Guide, par. 30,453, at p. 9759, and cases cited therein at n. 8; Fabula v. Buck, supra, 598 F.2d, at 872-873; Hendrickson v. Noot, ___ F. Supp. ___, CCH Medicare & Medicaid Guide, par. 30,499, at p. 9920 (D. Minn. 1980). Contra, Dawson v. Myers, ___ F.2d ___, CCH Medicare & Medicaid Guide, par. 30,501, at p. 9927 (9th Cir. 1980), pet. for rehearing pending.

optional categorically needy. It was Congress' intention that no potential Medicaid recipients should be subject to more restrictive eligibility conditions than the cash recipient categorically needy had applied to them. The new regulations merely sought to effect that goal, so that all aged, blind, and disabled applicants for medical assistance would be subject to the same eligibility conditions.

Once that point is recognized, the action of HHS must be viewed as appropriate. The agency has ensured that all SSI eligibles will be eligible for Medicaid by inserting the SSI eligibility rules for deeming into the Medicaid regulations applicable to the SSI states. Thus, Judge Ross' insistence that HHS can "cite[] no SSI statute which demands the use of the term 'actually contributed' in the current regulation," Ross Op., at 15 (App. "A", at 23a), a factor on which he appears to place great significance, is irrelevant. Indeed, there is no such language, but the SSI statute details that, after the spouses separate, deeming must cease immediately when one spouse is not eligible for SSI, 42 U.S.C. §1382c(f)(1),[22] and after six months when both spouses are

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[22] For administrative reasons, recognition of the separation and thus the cessation of deeming cannot be effected until the end of the calendar month in which they separate. McM. Op., at 44 (App. "A", at 59a).

eligible. 42 U.S.C. §1382c(b).[23] After the relevant periods of separation, the spouses are treated as separate economic units by the SSI statute, and they must therefore be similarly treated under the Medicaid regulations.

The regulations accomplish that. They track the SSI statute. As Judge McMillian noted:

> "These [SSI] periods of deeming should be familiar to the reader; they are precisely the periods of deeming specified in the Medicaid regulation at issue, 42 C.F.R. §435.723. This congruence is not coincidental; it is compelled by the relationship between the SSI and the Medicaid programs." McM.Op., at 46 (App. "A", at 61a-62a).[24]

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[23] The treatment of physically separated spouses as one couple for six months after separation, when both are eligible, represents a congressional desire to discourage fraudulent separations; because an SSI couple's benefit is lower than two separate benefits, see 42 U.S.C. §§1382(b)(1), (2), the statute defined a couple separated for less than six months as if the spouses were still living together. 42 U.S.C. §1382c(b) (definition of "eligible spouse"). See H.Rep.No. 92-231, 92d Cong., 2d Sess. (1972), reprinted in [1972] U.S. Code Cong. & Admin. News, 5136.

[24] For a more complete discussion of how the SSI statute on this point is structured, see McM.Op., at 40-46 (App. "A", at 54a-61a).

The action of the Eighth Circuit in affirming the district court thus invalidates an HHS regulation which was specifically written to effect an explicit congressional intention of tying Medicaid eligibility to SSI eligibility in the SSI states. Congress wrote the Medicaid statute so that the aged, blind and disabled applying for medical assistance would have the same eligibility conditions applied to them as were applied under the SSI statute. Congress gave states the options of including the medically needy and certain categorically needy. But it did not intend for different rules to be applied among those categories. That option was provided only in 42 U.S.C. §1396a(f). If a state chose to be an SSI state, it was tied into the SSI eligibility conditions.

The courts have consistently recognized that the was the proper interpretation of the interrelationship of the two statuts. HHS attempted to spell out these requirements in this deeming context through the challenged regulation; it was not only a reasonable effort to effect Congress' intent, but it was virtually the only way to ensure that SSI eligibles were subject to the SSI eligibility conditions in this situation.[25/] The Eighth Circuit, however, has ignored the congressional intent,

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25/ In the only decision considering the validity of state deeming regulations in an SSI state, the issue of the propriety of these federal regulations was not a factor. Griswold v. Page, TCA 77-0712 (N.D. Fla. 1977), reported at CCH Medicare & Medicaid Guide, par. 28,537.

has repudiated HHS' effort to effect that intent, and has contradicted numerous other courts which have recognized the integration of SSI and Medicaid eligibility. The decision below thus has the potential for encouraging other states to ignore HHS regulations which they find not to be in their "best interests."

Judge Ross has supported his analysis by noting that the "rigid and costly imposition of unreasonable SSI regulations [are] inappropriate and unfair to the taxpayer and welfare recipients of the state." Ross Op., at 18 (App. "A", at 27a). In short, he and other judges object to the burden which the regulation allegedly places on Iowa. Any burden, however, has been placed there not by the regulations, but by Congress. HHS was merely undertaking to implement a congressional directive.

Iowa had, and still retains, options under the Medicaid statute which might assuage its dissatisfaction. It can drop coverage of the optional categorically needy, or it can seek 209(b) status, which might free it from the "rigid . . . imposition of unreasonable SSI regulations." Congress has given the states considerable flexibility to contour their Medicaid programs to meet their respective needs. If a state still feels that there is too much rigidity, it should seek to amend the statute.

It is not a court's function, however, to rewrite a statute to provide flexibility where Congress intended none. Those changes, if any, must come from that latter body. "[I]ssues

of legislative policy . . . [are] better addressed to the wisdom of Congress than to the judgment of this Court." Miller v. Youakim, 99 S.Ct. 957, 968 n.21 (1979), quoting Marquette National Bank v. First of Omaha Service Corp., 99 S.Ct. 540, 550-551 (1978). It is improper for a Court of Appeals to fashion a decision which is plainly antagonistic to the statutory framework and which ignores settled and explicit law. States should not be encouraged to disavow federal directives merely because the states are dissatisfied with the policy.

The Eighth Circuit has abetted Iowa's scheme to ignore its obligations under the controlling federal scheme. In so doing, it has established a precedent which ranges far beyond the immediate confines of the deeming issue and which throws considerable doubt onto the integration of Medicaid and SSI.

CONCLUSION

For the reasons presented above, a writ should issue to review the decision of the Eighth Circuit.

Respectfully submitted,

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DATED: July, 1980

APPENDICES

APPENDIX A

United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 78-1664

Elvina M. Herweg, by her husband and next friend, Darrell E. Herweg, and Darrell E. Herweg, and all others similarly situated,	*	
Appellants,	*	Appeal from the United States District Court for the Southern District of Iowa.
v.	*	
Robert D. Ray, individually and in his capacity as Governor of the State of Iowa, and Kevin J. Burns, individually and in his capacity as Commissioner of the Iowa Department of Social Services,	*	
Appellees.	*	

Submitted: September 10, 1979

Filed: March 18, 1980

Before GIBSON, Chief Judge, * LAY, HEANEY, BRIGHT, ROSS, STEPHENSON, HENLEY, and McMILLIAN, Circuit Judges.

*The Honorable Floyd R. Gibson was Chief Judge of the Eighth Circuit at the time this case was

(cont. p. 2a)

ORDER

Pursuant to the attached opinion, the judgment of the district court is affirmed by an equally divided court, except that portion relating to the sources of income the state may consider as available to Medicaid applicants and recipients, which is reversed and remanded.

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* (cont.)
submitted and took senior status on December 31, 1979, before the opinion was filed.

United States Court of Appeals

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*The Honorable Floyd R. Gibson was Chief Judge of the Eighth Circuit at the time this case was

(cont. p. 4a)

ROSS, Circuit Judge.

Elvina M. Herweg and her husband, Darrell E. Herweg, individually and as representatives of a class, appeal a decision by the district court[1] making Medicaid eligibility determinations affecting the Herwegs and the class. The district court, in January 1978, enjoined the state of Iowa from determining Medicaid eligibility by "deeming," through the use of an arbitrary formula, the income of a noninstitutionalized spouse as available to the institutionalized spouse. Herweg v. Ray, 443 F. Supp. 1315, 1320 (S.D. Iowa 1978).

Later, upon request of the parties, the district court defined the contours of relief it decided to be appropriate. Based on the relevant Medicaid statute, 42 U.S.C. § 1396a(a)(17) the district court disapproved deeming by an arbitrary formula but approved Iowa's use of a factual determination in each case as to the amount the state could consider as available from the noninstitutionalized spouse for the care of the institutionalized spouse. Herweg v. Ray, Civil No. 77-222-1, slip op. at 3 (S.D. Iowa July 10, 1978). Appellants, however, contend that this solution violates Medicaid statutes and regulations. They argue that Medicaid eligibility must be determined only on the basis of

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* (cont.)
submitted and took senior status on December 31, 1979, before the opinion was filed.

[1] The Honorable W. C. Stuart, Chief Judge, United States District Court for the Southern District of Iowa.

contributions actually made by the noninstitutionalized spouse to the institutionalized spouse's care. They further argue that if the spouse does not actually contribute, even though financially able, the state should determine that the institutionalized spouse is eligible and make full payment of benefits. Then if it desires, the state could sue the financially responsible spouse under its relative responsibility law.

Because the district court invalidated Iowa's "deeming" procedure on statutory grounds the constitutional claims of the plaintiffs were not reached. Herweg v. Ray, supra, 443 F. Supp. at 1320. Those claims allege that "deeming" violates the due process clause and the equal protection clause by creation of an irrebuttable presumption and an arbitrary classification.

Before addressing the issues raised by appellants, we will review Iowa's prior "deeming" procedures as applied to the Herwegs' situation.

Since August 1976, 47 year old Elvina Herweg has been in a comotose state which resulted from two cerebral hemorrhages. Mrs. Herweg was placed in a long-term care facility in November 1976.

Darrell Herweg was employed as a butcher when this action was instituted and his gross monthly income was $1,350 (net $1,032). The Herwegs have three teenage daughters at home.

In January 1977, Mr. Herweg applied for Medicaid assistance for his wife. Mrs. Herweg

was found eligible for Medicaid and Mr. Herweg was required to pay $234.80 per month toward his wife's medical expenses which were approximately $1,374 per month. The "deemed" amount, $234.80 per month, was arrived at by use of a formula which excluded half of Mr. Herweg's earned income and then excluded standard living allowances for Mr. Herweg and the children at home. Standard exclusions for work expenses and the personal needs of the institutionalized spouse were also allowed.

In June 1977, apparently upon advice from HEW, the state of Iowa's formula for determining eligibility was changed in that one-half of Mr. Herweg's earned income was not excluded. This change resulted in a determination that Mrs. Herweg was no longer eligible for Medicaid and led to the filing of this suit. After the district court granted a temporary restraining order, the state again changed the formula to exclude one-half of Mr. Herweg's earned income. Mrs. Herweg was again determined eligible for Medicaid and based on increased living allowance exclusions, $150.30 of Mr. Herweg's monthly income was deemed available for Mrs. Herweg's medical expenses.

The district court held that the state of Iowa's method of "deeming" through the use of an arbitrary formula conflicted with 42 U.S.C. § 1396a(a)(17) and the applicable regulations 45 C.F.R. 248.3(b)(a)(ii) (currently, 42 C.F.R. 435.723(d)(1978)). Id. at 1320. However, without specifically ruling on the validity of the regulation, the district court found that under the statute,

42 U.S.C. § 1396a(a)(17) the state should be allowed to make a factual determination of actual income and expenses of the noninstitutionalized spouse and determine a reasonable amount to require as a contribution. Id. at 1320. The state of Iowa submitted to the district court proposed procedures for making such a factual determination in each case and the district court approved the state's new procedures as entirely consistent with federal law.

It is important to note that the state of Iowa is not challenging the district court's determination that "deeming" through the use of an arbitrary formula is contrary to § 1396a(a)(17). Rather, the conflict involved in this appeal is the method the state of Iowa now uses, which is a factual determination of income actually received and expenses necessarily incurred, to determine the amount of money a state may require as a contribution from the noninstitutionalized spouse who is reasonably able to pay some of the medical expenses of his Medicaid eligible, institutionalized spouse.

The district court certified the class, as requested by plaintiffs, as including instances where the institutionalized spouse is eligible for Medicaid.[2] However, it is clear that the procedures plaintiffs challenge involve the method

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[2]The district court certified the class as consisting of "all married couples residing in Iowa of which: (1) one spouse is eligible for Medicaid

(cont. p. 8a)

used to calculate the institutionalized spouse's available income. This same calculation is used not only when determining the amount of the required contribution as in the case of the Herwegs, but also in determining initial eligibility for Medicaid. Therefore, our concern in this case must of necessity focus on not only the application of the procedure to one who is eligible for Medicaid but also the application of the procedure to one who seeks Medicaid eligibility but whose income and expenses may justify the denial of eligibility under the statute.

Jurisdiction

In view of the recent Supreme Court decision in Chapman v. Houston Welfare Rights Organization, 441 U.S. 600 (1979), a brief review of jurisdiction is necessary. Chapman involved a challenge to state welfare regulations based solely on the grounds that the regulation conflicted with the Social Security Act. The Supreme Court indicated that "an allegation of incompatibility between federal and state statutes and regulations does not, in itself, give rise to a claim 'secured by the Constitution' within the meaning of

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2 (cont.)
and requires institutionalization; and (2) the other spouse is not institutionalized and (3) the non-institutionalized spouse has income which is, under current state procedures, being deemed available to the institutionalized spouse." Herweg v. Ray, 443 F. Supp. 1315, 1320 (S.D. Iowa 1978).

[28 U.S.C.] § 1343(3)." Id. at 615. The Court also rejected the argument "that § 1983 is an Act of Congress 'providing for equal rights' within the meaning of §1343(3)" or a "statute 'providing for the protection of civil rights, including the right to vote'" within the meaning of § 1343(4). Id. at 617-18. The Supreme Court then held that "[t]he Social Security Act does not deal with the concept of 'equality' or with the guarantee of 'civil rights,' as those terms are commonly understood." Id. at 621. Therefore, the Social Security Act is not included within the meaning of §1343(3) or (4). Id. at 621. However, neither Chapman nor the case with which it was consolidated on review, Gonzales v. Young, involved any constitutional claims other than a basic supremacy clause challenge. Further, the Supreme Court specifically noted that "[w]here the underlying right is based on the Constitution itself, rather than an Act of Congress, § 1343(3) obviously provides jurisdiction." Id. at 618 n. 36. The Supreme Court in Chapman did not alter its previous decision in Hagans v. Levine, 415 U.S. 528 (1974). In Hagans, the Supreme Court approved the review of a statutory conflict claim under a pendent jurisdiction rationale where the district court had found a substantial constitutional question presented. Id. at 536. The Supreme Court also noted that:

> A [constitutional] claim is insubstantial only if '"its unsoundness so clearly results from the previous decisions of this court as to foreclose the subject and leave no room for the inference that the questions sought to

to be raised can be the subject of controversy."'

Id. at 538 (citations omitted).

In the present case, the complaint alleged a violation of the due process clause, in that "deeming" constitutes an irrebuttable presumption not rationally related to a legitimate state interest. The plaintiffs also raised an equal protection claim regarding different treatment of married versus unmarried Medicaid recipients.

Although the district court specifically did not reach the constitutional claims, we hold that the claims present substantial constitutional questions. Thus, the district court possessed pendent jurisdiction over the statutory issues based on its proper jurisdiction over the constitutional claims under § 1983 and § 1343(3).

The Medicaid Statute

The district court found that Iowa's "deeming" procedure was contrary to both the relevant statute § 1396a(a)(17) and the relevant HEW regulation 45 C.F.R. § 248.3(b) [currently 42 C.F.R. § 435.723 (October 1, 1978)]. Herweg v. Ray, supra, 443 F. Supp. at 1320. However, the district court also found that "deeming" income to be unavailable unless actually contributed, as required by the regulation, "seemed" contrary to congressional intent. Id. at 1320. Thus, the district court approved the state of Iowa's new procedure for making a reasonable evaluation as consistent with § 1396a(a)(17). However, there

is no dispute that the new procedure approved by the district court is contrary to regulation, § 435.723. Therefore, the issue this court must face is whether the regulation is an incorrect interpretation of the statute, § 1396a(a)(17), thus justifying the result reached by the district court. Other courts have consistently struck down "deeming"; however, the courts have varied or been unclear on the method the state may then use to enforce financial responsibility.[3] But see

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[3] Decisions which allow the state to make a reasonable evaluation:

Norman v. St. Clair, Nos. 77-1722, 79-2471 (5th Cir. Jan. 28, 1980) (approving "deeming" but ordering that "deeming" be done in a flexible manner taking into account the "expenses necessary for the spouse to live in the community" slip op. at 2714); Gray Panthers v. Secretary of HEW, 461 F. Supp. 319, 323 (D.D.C. 1978), appeal docketed, No. 79-1334 (D.C. Cir. March 27, 1979) (citing Herweg with approval and approving consideration of spouse's income by reasonable standards); Franssen v. Juras, 406 F. Supp. 1375, 1379 (D. Ore. 1975) (barring deeming under old HEW regulation and allowing state to make a reasonable evaluation of income or reenact a relative responsibility law).

Decisions which contain language which would appear to allow the state to make a reasonable evaluation:

(cont. p. 12a)

Norman v. St. Clair, Nos. 77-1722, 79-2471 (5th Cir. Jan. 28, 1980) and discussion, infra, at 17, n. 6.

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3 (cont.)

Rubin v. Creasy, No. C-1-78-810, slip op. at 17-18 (S.D. Ohio April 13, 1979) (temporary restraining order citing Herweg with approval and barring deeming of resources without a factual finding of actual availability); Foard v. Gibson, C-C-78-0319, slip op. at 4 (W.D. N.C. March 29, 1979)(barring "deeming" practices which disregard the actual living costs of the noninstitutionalized spouse); Burns v. Vowell, 424 F. Supp. 1135, 1141 (S.D. Tex. 1976) (preliminary injunction barring deeming under old HEW regulation as to named plaintiffs; court indicated that income of a noninstitutionalized spouse can be considered through the application of reasonable standards).

Decisions which do not indicate what recourse, if any, the state has for enforcing financial responsibility:

Allen v. Califano, No. 78-0212, slip op. at 2 (D. Utah August 23, 1979) (barring "deeming" of income which is not in fact available); Griswold v. Page, TCA 77-0712, slip op. at 6-7 (N.D. Fla. May 20, 1977) (barring "deeming" by state as of effective date of the new HEW regulation); Krygier v. Buscaglia, Civ-78-83, slip op. at 8 (W.D.N.Y. May 2, 1979), stay pending appeal, No. 79-7386 (2d Cir. July 17, 1979) (district court preliminarily

(cont. p. 13a)

In undertaking this review, we recognize that "the construction of a statute by those charged with its execution should be followed unless there are compelling indications that it is wrong ***." Beal v. Doe, 432 U.S. 438, 447 (1977); New York Dept. of Soc. Services v. Dublino, 413 U.S. 405, 421 (1973); Red Lion Broadcasting Co. v. FCC, 395 U.S. 367, 381 (1969). "But the courts are the final authorities on issues of statutory construction

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3 (cont.)

enjoined enforcement of state "deeming" regulation unless a hearing is first affored to the noninstitutionalized spouse).

Decisions which allow the state to use only its relative responsibility laws to enforce financial responsibility:

Brown v. Stanton, No. 79-1459 (7th Cir. Jan. 30, 1980) ("proper method of enforcing spousal responsibility is through state spousal support statutes" slip op. at 14); Hanke v. Nyhus, 470 F. Supp. 742, 746 (D. Minn. 1979) and Advisory Council v. Kelly, 470 F. Supp. 747, 752 (D. Minn. 1979) (court found that accumulated property [rather than income] of noninstitutionalized spouse was not available unless it was contributed; however, state could pursue claim for contribution under its relative responsibility laws); Manfredi v. Maher, 435 F. Supp. 1106, 1115 n.18 (D. Conn. 1977) (barring deeming and allowing state to enforce its relative responsibility laws).

and 'are not obliged to stand aside and rubber-stamp their affirmance of administrative decisions that they deem inconsistent with a statutory mandate or that frustrate the congressional policy underlying a statute.'" (Citations omitted.) Volkswagenwerk v. FMC, 390 U.S. 261, 272 (1968).

42 U.S.C. § 1396a(a)(17) provides in pertinent part:

> (a) A State plan for medical assistance must--
>
> (17) include reasonable standards * * * for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient * * * (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 * * *.

(Emphasis supplied.)

The legislative history of § 1396a(a)(17) is set out in S. REP. No. 404, 89th Cong., 1st Sess. 4, reprinted in [1965] U. S. CODE CONG. & AD. NEWS 1943, 2018:

> Another provision is included that requires States to take into account only such income and resources as (determined in accordance with standards prescribed by the Secretary), are actually available to the applicant or recipient and as would not be disregarded (or set aside for future needs) in determining the eligibility for and the amount of the aid or assistance in the form of money payments for any such applicant or recipient under the title of the Social Security Act most appropriately applicable to him. Income and resources taken into account, furthermore, must be reasonably evaluated by the States. These provisions are designed so that the States will not assume the availability of income which may not, in fact, be available or overevaluate income and resources which are available. Examples of income assumed include support orders from absent fathers, which have not been paid or contributions from relatives which are not in reality received by the needy individual.
>
> The committee has heard of hardships on certain individuals by requiring them to provide support and to pay for the medical care needed by relatives.

> The committee believes it is proper to expect spouses to support each other and parents to be held accountable for the support of their minor children and their blind or permanently and totally disabled children even though 21 years of age or older. Such requirements for support may reasonably include the payment by such relative, if able, for medical care. Beyond such degree of relationship, however, requirements imposed are often destructive and harmful to the relationships among members of the family group. Thus, States may not include in their plans provisions for requiring contributions from relatives other than a spouse or the parent of a minor child or children over 21 who are blind or permanently and totally disabled. Any contributions actually made by relatives or friends, or from other sources, will be taken into account by the State in determining whether the individual applying for medical assistance is, in fact, in need of such assistance.

(Emphasis supplied.)

We note that although a state may not "assume the availability of income," Congress did specify that state "requirements for support may reasonably include the payment by [a spouse], if able, for medical care." However, "States may not include * * * provisions for requiring contributions from relatives other than a spouse * * *." But, "contributions actually made by relatives or

friends * * * will be taken into account * * *."

In contrast, the relevant regulation 42 C.F.R. § 435.723 (October 1, 1978) indicates:

> § 435.723 Financial responsibility of spouses.
>
> (a) If the agency provides medicaid to SSI recipients, it must meet the requirements of this section in determining eligibility of aged, blind and disabled individuals under the optional coverage provisions of §§ 435.210, 435.211, and 435.231.
>
> * * * *
>
> (d) If only one spouse in a couple applies or is eligible and they cease to live together, the agency must consider only the income and resources of the eligible spouse that are actually contributed to the eligible spouse after the month in which they cease to live together.

(Emphasis supplied.)

It is interesting to note that earlier HEW interpretation of § 1396a(a)(17) directly followed the statute. Those regulations 45 C.F.R. 248.3(b)(1) (October 1, 1975) stated "that only such income and resources as are actually available will be considered and that income and resources will be reasonably evaluated." We find that the term "available" in § 1396a(a)(17) when read in conjunction with the

legislative history cannot by any stretch of the imagination be translated into the "actually contributed" language of the current regulation. We find that HEW's interpretation of the statute is wrong. In effect it has substituted the words "actually contributed" for the statutory word "available." In our view, which is based partially on the legislative history quoted, the words "actually available" encompass funds which a spouse has available to contribute even though he or she does not actually contribute them to the spouse.

Furthermore, the statute specifically allows a state to consider the financial responsibility of a spouse in determining eligibility. Nothing in the statute or legislative history limits a state to enforcing this responsibility only through use of the state's relative responsibility law. We find that HEW's regulation nullifies the congressional intent of § 1396a(a)(17)(D), which indicates the financial responsibility of a spouse can be considered by a state.[4] Leave the state of Iowa

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[4]In Batterton v. Francis, 432 U.S. 416, 426 (1977) a narrower scope of review for HEW regulations was established in a situation where the statute "expressly delegated to the Secretary the power to prescribe standards for determining what constitutes 'unemployment' for purposes of AFDC-UF eligibility." Id. at 425. This narrower review would cause the regulation to be "set aside only if the Secretary exceeded his statutory authority or if the regulation is 'arbitrary, capricious, an abuse of discretion or otherwise

(cont. p. 19a)

to sue retroactively and periodically for payments the noninstitutionalized spouse could reasonably afford, is to us an inequitable and burdensome result requiring repeated lawsuits against the same person. Furthermore, we will not force Iowa to grant Medicaid eligibility to a person whose spouse is extremely wealthy but whose

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4 (cont.)

not in accordance with law.' 5 U.S.C. §§ 706(2)(A), (C)." Id. at 426.

However, subsection (D) of § 1396a(a)(17) must be read as a limitation on the Secretary's ability to prescribe standards for what constitutes "available" income under subsection (B) of the statute. Furthermore, in Batterton Congress had given HEW the specific task of defining one term, "unemployment," rather than the general delegation of establishing standards which are "consistent with the objectives of this subchapter." § 1396a(a)(17)(A). Specifically, the statute in Batterton "requires a participating State to provide assistance where a needy child 'has been deprived of parental support or care by reason of the unemployment (as determined in accordance with standards prescribed by the Secretary) of his father.' 42 U.S.C. § 607(a)." Id. at 419. In view of the difference in statutory mandate, we do not believe the standard of review under Batterton applicable to this case. However, even under the narrower test of Batterton, we would hold that the regulation must fall.

income cannot be considered (unless actually contributed) after the first month of institutionalization. In addition to the legality of the question, a contrary result would be most unfair to the noninstitutionalized spouse who does contribute what he can to the care of his spouse or to the taxpayers who pay for such care when they are not legally obligated to do so.

Both the Fifth Circuit in Norman v. St. Clair, Nos. 77-1722, 79-2471, slip op. at 2710 (5th Cir. Jan. 28, 1980) and Judge Pell in Brown v. Stanton, No. 79-1459 (7th Cir. Jan. 30, 1980) (dissenting in part) recognized the inevitable consequences of limiting a state's recourse to its relative responsibility laws. Judge Pell, in the course of an unusually short and cogent dissent stated:

> Under [that result], there is an open invitation for the spouse to decide that he or she does not wish to make the excess payment. In this era of inflation, and giving consideration to the human inclination not to pay out money when one doesn't have to, I think it reasonable to conclude that few would decline the invitation.

Slip. op. at 18.

The SSI-Medicaid Link

Upon request of the court, HEW filed an amicus brief concerning the validity of the regulation, § 435.723. HEW argues that there is a link between SSI (Supplemental Security Income) and Medicaid eligibility standards based on 42 U.S.C.

§ 1396a(a)(10)(A). Based on this link, HEW believes that an SSI statute, 42 U.S.C. § 1382c (f)(1) dictates that income be "deemed" for at least the first month of institutionalization where there is an ineligible noninstitutionalized spouse.[5]

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[5]HEW's brief considers at much greater length the validity of deeming for six months where there is an eligible couple under 42 C.F.R. § 435.723(c) but this subsection was not considered by the district court and we will not consider it here. However, it appears that the state of Iowa does not "deem" in the instance where both spouses are in such a low income bracket as to constitute an eligible couple. HEW justifies this six month "deeming" based on SSI provisions of 42 U.S.C. § 1382c(b) wherein an "eligible spouse" is one "who has not been living apart" from their eligible husband or wife "for more than six months." However, this six month rule was placed in the SSI statute to discourage eligible couples from voluntarily living separate in order to receive higher benefits. See Mansfield v. Weinburger, 398 F. Supp. 965, 969 (D.D.C. 1975). Additionally, a 1976 amendment to 42 U.S.C. § 1382(e)(1)(B)(ii), Pub. L. 94-566, § 502 shows a congressional desire to consider individually the finances of an eligible couple where one spouse is institutionalized. We can find no logic in "deeming" for a longer period of time where there is an eligible couple than where only one spouse is eligible.

However, HEW does not cite any SSI statute that dictates the "actually contributed" language of the Medicaid regulation, § 435.723.

42 U.S.C. § 1396a(a)(10)(A), the Medicaid statute, indicates that a state plan for medical assistance must:

> (10) provide--
>
> (A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter;

The SSI statute on which HEW bases its argument is 42 U.S.C. § 1382c(f)(1), which states:

> (f)(1) For purposes of determining eligibility for and the amount of benefits for any individual who is married and whose spouse is living with him in the same household but is not an eligible spouse, such individual's income and resources shall be deemed to include any income and resources of such spouse, whether or not available to such individual, except to the extent determined by the Secretary to be inequitable under the circumstances.

(Emphasis supplied.)

In response to HEW, appellants argue that the Medicaid statute, § 1396a(a)(17) does not allow any deeming, even for one month. Appellants state that the "SSI statute did not implicitly or explicitly alter the meaning and intent of the Medicaid provisions regarding availability." But appellants also state that if we reject their argument that § 1396a(a)(17) only allows actually contributed income to be considered, then appellants will agree with HEW that the SSI-Medicaid link justifies the current regulation.

We believe that the answer to this conflict lies in the language of § 1396a(a)(17), itself. Deeming by use of an arbitrary formula is not allowed. However, the statute does allow a reasonable evaluation of income available to the applicant or recipient, taking into account the financial responsibility of their spouse.

HEW, as previously indicated, cites no SSI statute which demands the use of the term "actually contributed" in the current regulation, 435.723, rather than the term used in the Medicaid statute (and previous HEW regulations) "available." The SSI statute HEW does cite, 42 U.S.C. § 1382c(f)(1) allows "deeming" by use of an arbitrary formula when an eligible person lives with their ineligible spouse. Apparently, HEW decided that where a couple does not live together (even involuntarily as in the institutionalized spouse's case) then the opposite of arbitrary "deeming" must apply--"actually contributed." However, this view fails to recognize the middle ground specifically provided for in § 1396a(a)(17) which the district court identified. That middle

ground is a reasonable evaluation of available income and expenses, which reasonable evaluation is also the opposite of arbitrary "deeming."

Additionally, the SSI statute, § 1382c(f)(1) provides that when an eligible spouse lives with her ineligible spouse, the eligible spouse's income is "deemed to include any income" of the ineligible spouse "whether or not available." Therefore, under the SSI statute there is no need to define the term "available"; its definition is essentially irrelevant. In contrast, the Medicaid statute, § 1396a(a)(17) demands that the standards drawn consider availability, thus, the effort to define "available" must be controlled by the Medicaid statute not the SSI statute.

Although Norman v. St. Clair, supra, and Brown v. Stanton, supra, involved § 209(b) states rather than an SSI-state such as Iowa, it appears that in Norman the Fifth Circuit reached essentially the same result as we do here, by reasoning from the SSI-states' situation to that of a "§ 209(b) state." The court in Norman in discussing the previously cited SSI statute, § 1382c(f)(1), indicates the following:

> Thus under certain circumstances Medicaid eligibility determinations in an "SSI state" must, because of the statutory mandate in the SSI legislation, take into account income that is deemed available, without regard to whether that income is actually contributed. Since this statutory mandate exists concurrently in the Medicaid law with the

> provision of 42 U.S.C. § 1396a(a)(17) directing that only income which is "available" be taken into account, it must be concluded that the income deemed to Medicaid applicants pursuant to provisions of law applicable to SSI states is available income. A concept of available income which includes income deemed to spouses in SSI states must also encompass income deemed[6] to spouses in the more restrictive programs of the § 209(b) states.

Slip op. at 2709-10.

There are also additional reasons for finding SSI eligibility requirements inapplicable to the institutionalized spouse situation. In the institutionalized situation there is a "gap," which as we will explain, has been closed by states such as Iowa, by electing to cover optional groups.

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[6]The Fifth Circuit in Norman reached the result that "flexible" deeming by the state is mandated under the statute. That result is essentially similar to our approval of a reasonable evaluation of income. The difference is basically semantics. We believe that the term "deeming" conotates the use of an arbitrary or standardized formula and thus we decline to characterize our result as "reasonable deeming."

Congress apparently linked SSI and Medicaid because a person who needs financial assistance to live (SSI) would naturally need financial assistance for medical care. However, under 42 U.S.C. § 1382(e)(1)(B)(i) the maximum SSI benefit payable to an institutionalized individual who does not have an eligible spouse is $300 per year or $25 per month reduced by nonexcluded income. Congress authorized this amount for institutionalized individuals "to enable them to purchase small comfort items not supplied by the institution." H.R.REP. No. 92-231, 92nd Cong., 2d Sess. 3, reprinted in [1972] U. S. CODE CONG. & ADM. NEWS 4989, 5136. However, since the $25 payment is reduced by nonexcluded income, it seems apparent that many institutionalized individuals would not be eligible for SSI benefits although they would be in dire need of Mdeicaid. This "gap" in the SSI-Medicaid scheme was remedied by providing that a state may provide Medicaid coverage to optional groups, including (1) those who are SSI eligible but do not receive benefits, 42 C.F.R. § 435.210; (2) those who are ineligible for SSI because of lower income standards used to determine eligibility for institutionalized individuals, but who would be SSI eligible if not institutionalized, 42 C.F.R. § 435.211; and (3) institutionalized individuals who are not SSI eligible but who have income below a certain level. 42 C.F.R. § 435.231 (federal funds are available only for those persons whose income is below 300 percent of the SSI individual benefit amount, 42 C.F.R. § 435.1005).

In the situtation where states such as Iowa elect to provide medical coverage to optional

groups, some of whom are not eligible to receive SSI benefits, we find the rigid and costly imposition of unreasonable SSI regulations inappropriate and unfair to the taxpayer and welfare recipients of the state. Each state is limited in the total amount its legislature will appropriate. If it is forced to pay the entire cost of institutionalizing a person whose spouse has more income than he reasonably needs, optional coverage will of necessity be reduced or eliminated in other areas.

AFDC Cases

Appellants also note that the Supreme Court has struck down state AFDC provisions which "deem" the income of a MARS (man assuming the role of spouse) as available to the family without a showing of actual contribution. Van Lare v. Hurley, 421 U.S. 338 (1975); Lewis v. Martin, 397 U.S. 552 (1970); King v. Smith, 392 U.S. 309 (1968).

Appellees, however, argue that these cases can be distinguished in that a MARS has no legal obligation of support. Appellants argue that although legal responsibility was an aspect of those cases, the Supreme Court's concern focused on the "actually available" language of AFDC regulations.

We agree with the state of Iowa that these cases are distinguishable in that no legal duty existed for the MARS to support or contribute to the family. The one exception to this absence of legal duty to support arose in Lewis v. Martin, 397 U.S. 552 (1970). In Lewis the state of California had passed a law which required a

MARS to make a financial contribution to the family. Id. at 553 n. 2. The Supreme Court rejected "deeming" of the MARS income even where there was a legal duty because "the likelihood of the MARS contributing his income to the children--even if legally obligated to do so--is sufficiently uncertain in the absence of the marriage tie, to prevent viewing him as a 'breadwinner' unless the bread is actually set on the table." Id. at 559.

The uncertainty of support presented in the MARS situation is simply not present in this case where the legal duty to support is created by marriage and by state statute, and the legislative history of § 1396a(a)(17) indicates that "[t]he committee believes it is proper to expect spouses to support each other * * *." Furthermore, the result reached by the district court--a reasonable evaluation--is less burdensome than the arbitrary "deeming" formula used to evaluate a MARS' income.

OTHER ISSUES: The district court found that Social Security benefits, Railroad Retirement Board annuities and Civil Service Commission annuities should be excluded from the sources of income the state may consider available to Medicaid applicants and recipients. Herweg v. Ray, Civil No. 77-222-1, slip op. at 2 (S.D. Iowa July 10, 1978). However, we believe these payments should be considered as available and their inclusion would constitute a reasonable evaluation of income within the meaning of § 1396a(a)(17). Furthermore, if the state's only recourse is through use of relative responsibility laws then these payments, no matter how large,

could not be attached. See Philpott v. Essex County Welfare Board, 409 U.S. 413, 415-16 (1973).

The Result

Our concern in this case, as expressed earlier, is the situation confronting the state when the noninstitutionalized spouse has more income than necessary for his own needs but chooses not to contribute any money to his institutionalized spouse who has little or no income. Under these circumstances the result advocated by other members of the court would force the state to first grant Medicaid eligibility to the institutionalized spouse, or take away the right of the state to require a contribution, and then sue the noninstitutionalized spouse retroactively and periodically for monies already expended by the state. Such a result is to us not only burdensome on the state but is contrary to the congressional intent reflected in § 1396a(a)(17). Plaintiffs have argued that our result--a reasonable evaluation of available income--will lead to eviction of the institutionalized spouse when the noninstitutionalized spouse fails to contribute the required amount. However, at oral argument counsel for the state of Iowa indicated that no such evictions have taken place using the current method. If institutionalized spouses are declared ineligible or are required to make a partial contribution, as here, we believe the necessary contribution will be made by the spouse rather than permitting eviction. We also believe that many more persons would "choose" not to support their institutionalized spouses if permitted to do so by the HEW regulation and if the only recourse of a state was a possible suit for past due payments

at some time in the distant future. The practical effect of upholding the appellants' position would be unfair to spouses who are properly making their contributions, would be very costly to the state of Iowa and would result in the diminution of welfare benefits to other more worthy recipients in Iowa's other welfare programs.

Our result also will eliminate the possibility of a totally inconsistent and inequitable situation occurring when the wealthier spouse is institutionalized. If for instance, Mr. Herweg had been institutionalized, but continued to receive income of $1,032 per month while leaving Mrs. Herweg at home with little or no income, the result would be devastating. Individualized assessment of income would make Mr. Herweg ineligible for Medicaid. This would occur because under Medicaid regulation, 42 C.F.R. § 435.725, deductions for income for support of spouse and children are made after the initial eligibility decision. Furthermore, these deductions cannot exceed basic subsistence levels leaving the spouse at home in poverty. Plaintiffs at an earlier point in this litigation appeared concerned with this dichotomy. In correspondence between the parties contained in the record of the district court counsel for plaintiffs stated:

> If it is the institutionalized spouse with the greater income, a different kind of problem exists. * * * [C]ombining income will be advantageous to the couple; in fact, it is a virtual necessity if the non-institutionalized spouse is to continue to live in the same environment. * * *

> Whether you [state of Iowa] phrase it as combining or not, it is important that a procedure be developed whereby income from the wealthier institutionalized spouse flows directly to the non-institutionalized spouse so that she can meet reasonable and necessary expenses.

Conclusion

The judgment of the district court is affirmed except it is reversed as heretofore indicated as to the sources of income the state may consider as available to Medicaid applicants and recipients. The state of Iowa may continue to use the procedures for evaluation of income approved by the district court, but only until such time as HEW issues regulations which comport with the true meaning and intent of § 1396a(a)(17) as set forth herein.

Judges Gibson, Bright and Henley concur in this opinion.

McMILLIAN, Circuit Judge.

For the reasons discussed below, I am unable to agree with Judge Ross's opinion. In my view, both deeming according to an arbitrary formula and deeming according to a factual evaluation of received income and necessary expenses, as approved by the district court and Judge Ross's opinion herein, are impermissible.

Standard of Review

As an initial matter, I accord greater weight to the interpretation made by HEW in the regulation at issue (42 C.F.R. § 435.723) than Judge Ross does. The question before us is whether the regulation is proper, not how the statutory term should be interpreted. E.g., Batterton v. Francis, 432 U.S. 416, 424 (1977). "Ordinarily, administrative interpretations of statutory terms are given important but not controlling significance." Id. However, Congress in § 1396a(a)(17)(B) has expressly delegated to the Secretary of HEW the power to prescribe standards for determining what constitutes "available" income and resources. That provision states that a state plan must "provide for taking into account only such income and resources as are, determined in accordance with standards prescribed by the Secretary, available to the applicant" when determining Medicaid eligibility. 42 U.S.C. § 1396a(a)(17)(B) (emphasis added).

> In a situation of this kind, Congress entrusts to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term. In exercising that responsibility, the Secretary adopts regulations with legislative effect. A reviewing court is not free to set aside those regulations simply because it would have interpreted the statute in a different manner.

The regulation at issue in this case is therefore entitled to more than mere

> deference or weight. It can be set aside only if the Secretary exceeded his statutory authority or if the regulation is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law."

Batterton v. Francis, supra, 432 U.S. at 425-26 (case citations and footnotes omitted).

Thus, the question is whether the federal regulation itself is a reasonable interpretation of the statutory provision. Whether or not the federal regulation is less reasonable than the state's regulation is beside the point. Moreover, "[e]ven if this were a contest as to which is more reasonable, the federal regulation would prevail." Aitchison v. Berger, 404 F. Supp. 1137, 1149 (S.D.N.Y. 1975), aff'd without published opinion, 538 F.2d 307 (2d Cir.), cert. denied, 429 U.S. 890 (1976).

Factual Background

This case involves a dispute over the interpretation of the word "available" in one part of the Medicaid statute, 42 U.S.C. § 1396a(a)(17)(B). It also involves the relationship between that statutory provision and another, 42 U.S.C. § 1396a(a)(17)(D), and certain regulations promulgated by the Secretary of HEW, in particular, 42 C.F.R. § 435.723.

Unfortunately, "[s]ince the welfare statutes now rival the Internal Revenue Code in complexity, one interprets them with less than robust confidence."

Lynch v. Philbrook, 550 F.2d 793, 795 (2d Cir. 1977). "As program after program has evolved, there has developed a degree of complexity in the Social Security Act and particularly the regulations which makes them almost unintelligible to the uninitiated." Friedman v. Berger, 547 F.2d 724, 727 n.7 (2d Cir. 1976), cert. denied, 430 U.S. 984 (1977). This is particularly true in the present case, which required unraveling the relationship between two Social Security programs, Supplemental Security Income (SSI) and Medicaid. Moreover, an examination of case law reveals that the courts have been less than uniform in their analysis of deeming and related questions. Compare Brown v. Stanton, No. 79-1459 (7th Cir. Jan. 30, 1980), with Norman v. St. Clair, No. 77-1722 (5th Cir. Jan. 28, 1980).

Medicaid is a cooperative federal-state program established in 1965, in Title XIX of the Social Security Act (hereinafter the Act), 42 U.S.C. § 1396 et seq. The basic purpose of Medicaid is to enable each state, as far as practicable under the conditions in each state, to furnish medical assistance to certain needy persons whose income and resources are insufficient to meet the costs of necessary medical services. 42 U.S.C. § 1396; e.g., Beal v. Doe, 432 U.S. 438, 444 (1977); Hodgson v. Board of County Commissioners, No. 79-1665 (8th Cir. Jan. 9, 1980) (slip op. at 5 n.8). The Medicaid program is jointly financed by the federal and state governments and administered by the states.

States are not required to institute a Medicaid program, but if they choose to do so, they must

submit to the Secretary of HEW a satisfactory state plan, describing the nature and scope of the state's Medicaid program, which must fulfill all the requirements of the Act. 42 U.S.C. § 1396a(a)(1)-(40). The Secretary of HEW, through the Administrator of the Health Care Financing Administration, has promulgated various regulations which supplement the statutory provisions in providing the framework within which participating states must develop and operate their Medicaid programs. E.g., Gray Panthers v. Secretary of HEW, 461 F. Supp. 319, 320 (D.D.C. 1978), appeal pending sub nom. Administrator, Health Care Financing Administration v. Gray Panthers, No. 79-1334 (D.C. Cir. 1980). Within the federal guidelines established by the federal statutory provisions and regulations, each participating state in its state plan determines eligible groups, types and ranges of services, payment levels for services, and administrative and operating procedures. "Participating states must, however, provide five general categories of medical services to individuals classified as 'categorically needy' [see discussion below]: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and x-ray services; (4) skilled nursing facilities, family planning services and supplies; and (5) physicians services and supplies; and (5) physicians services." Norman v. St. Clair, supra, slip op. at 4 (emphasis in original, footnote omitted). States must comply with the federal guidelines in order to be entitled to grants of federal funds in partial reimbursement for their expenditures in providing medical assistance. E.g., Johnson's Professional Nursing Home, Inc. v. Weinberger, 490 F.2d 841, 842-43 (5th Cir. 1974); Hanke v. Nyhus, 470 F. Supp. 742, 744 (D. Minn. 1979).

The statutory provision at issue provides in part that a state plan must

> include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient, . . . (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse. . . .

42 U.S.C. § 1396a(a)(17)(A)-(D). The Secretary of HEW has promulgated a regulation, 42 C.F.R. § 435.723(d), which interprets "available" to mean "actually contributed" in the case of couples separated by institutionalization. This regulation provides:

> If only one spouse in a couple applies or is eligible and they cease to live together, the agency must consider only the income and resources of the ineligible spouse that are actually contributed to the eligible spouse after the month in which they cease to live together.

I do not agree that the Secretary's interpretation of the statutory term "available" is inconsistent with the statute or Congressional intent. As discussed below, the deeming regulation is based upon SSI eligibility criteria and is mandated by the Medicaid statute itself, which defines Medicaid eligibility by referring to SSI eligibility.

Arguments of the Parties

As I understand the arguments of appellants and the state of Iowa, neither party argues that the Secretary has exceeded her authority in promulgating this regulation. Such an argument would be of doubtful merit in view of the broad empowering provision of the Social Security Act, 42 U.S.C. § 1302, and the "reasonably related" standard of review. E.g., Johnson's Professional Nursing Home, Inc. v. Weinberger, supra, 490 F.2d at 844, citing Mourning v. Family Publications Service, 411 U.S. 356, 369 (1973) (Truth-in-Lending Act).

Appellants argue that § 1396a(a)(17)(B), when read with the legislative history, mandates a contribution-in-fact or "actually available" standard. Appellants contend that deeming on any basis for any length of time is impermissible. The state of Iowa argues that its current practice of deeming using a factual evaluation of income actually received and expenses necessarily incurred is authorized by the financial responsibility provision § 1396a(a)(17)(D). This is the basic holding of the district court, 443 F.Supp. at 1319-20, and Judge Ross herein: that the regulation has "nullified" the intent of Congress in § 1396a(a)(17)(D) to permit

a state to consider the financial responsibility of spouses. Slip op. at 12.

To answer appllants' argument that deeming is absolutely prohibited under the statute, I note that neither the statute nor the legislative history is so explicit. What the statute says is that states may consider only such income and resources as are "available" to the applicant and expressly delegates to the Secretary the power to prescribe the standards for determining what constitutes available income and resources. 42 U.S.C. § 1396a(a)(17)(B). The Secretary has interpreted "available" income and resources to include, in the case where one spouse has applied or is eligible for Medicaid in a couple separated by institutionalization of that spouse, only the income and resources of the ineligible spouse actually contributed to the institutionalized, eligible spouse after the month in which they cease to live together or are separated by institutionalization. 42 C.F.R. § 435.723(d). Thus, deeming is required in such a case for a certain period. In short, "available" is a statutory "term of art" which has been reasonably interpreted by the Secretary in the regulation at issue. Brief of the Department of HEW as amicus curiae at 17. See Batterton v. Francis, supra, 432 U.S. at 427-28 (administrative interpretation of statutory term "unemployment" in Title IV (AFDC) of the Social Security Act § 407(a), 42 U.S.C. § 607(a)).

The state of Iowa's argument that the deeming of income "without end" is permissible can be answered along similar lines. The Secretary has interpreted the statutory term "available" to require

deeming for only limited periods, up to a maximum of six months, depending upon whether one or both members of a couple are otherwise eligible for SSI and "cease to live together" or separated by institutionalization. 42 C.F.R. § 435.723(b), (c), (d).

As noted by the district court below, 443 F. Supp. at 1318-19, and Judge Ross herein, slip op. at 10-11, the voluminous legislative history of the Medicaid statute indicates that

> [t]hese provisions [§ 1396a(a)(17(A)-(D)] are designed so that the states will not assume the availability of income which may not, in fact, be available or over-evaluate income and resources which are available. Examples of income assumed include support orders from absent fathers which have not been paid or contributions from relatives which are not in reality received by the needy individual.

S. Rep. No. 404, 89th Cong., 1st Sess. 78, reprinted in [1965] U.S. CODE CONG. & AD. NEWS 1943, 2018 (hereinafter S. Rep. No. 404). The Secretary's interpretation of "available" in the regulation as "actually contributed" accurately implements the expressed Congressional intent that states make Medicaid eligibility decisions with "real rather than presumed dollars." Franssen v. Juras, 406 F. Supp. 1375, 1378 (D. Ore. 1975).

The specific reference in the legislative history to the consideration of "available" income and resources supports both the Secretary's primary role in defining "available" and the Secretary's

interpretation of "available" as contribution-in-fact or "actually contributed" in the regulation:

> Another provision [§ 1396a(a)(17)(B)] is included that requires States to take into account only such income and resources as (determined in accordance with standards prescribed by the Secretary), are actually available to the applicant or recipient and as would not be disregarded (or set aside for future needs) in determining the eligibility for and the amount of the aid or assistance in the form of money payments for any such applicant or recipient under the title of the Social Security Act most appropriately applicable to him [or her].

S. Rep. No. 404, supra (emphasis added). The deeming regulation treats the income and resources of an aged, blind or disabled individual under Medicaid in exactly the same manner as SSI, which is the title of the Social Security Act (Title XVI) "most appropriately applicable" to an aged, blind or disabled individual. Under SSI, the income and resources of spouses is deemed to be available to each other as long as they share the same household and, if the couple is separated, for up to six months depending upon the eligibility status of each spouse. See discussion below.

Of course, the more difficult question raised by the state of Iowa's argument is whether the "actually contributed" language in the regulation implementing § 1396a(a)(17)(B) has in effect "nullified" § 1396a(17)(D). See slip op. at 12;

Franssen v. Juras, supra, 406 F. Supp. at 1380 (Goodwin, J., dissenting). I agree with Judge Ross that § 1396a(a)(17)(D) specifically allows states to consider the financial responsibility of spouses (and parents). However,

> [i]t should be observed from the outset that § 1396a(a)(17)(D) does not require interspousal income attribution [deeming], nor does it stand for the proposition that the entirety of a spouse's income be automatically attributed to the other spouse in every instance. . . . Rather, the language in § 1396a(a)(17)(D), which refers to spouses, merely provides that the blanket prohibition which is imposed in that subsection upon such income attributions as are predicated on financial responsibility shall not act as a total barrier to all income attributions as between spouses.

Manfredi v. Maher, 435 F. Supp. 1106, 1109 n. 5 (D. Conn. 1977) (1972 option state) (emphasis in original); see also Gray Panthers v. Secretary of HEW, supra, 461 F. Supp. at 322; Herweg v. Ray, supra, 443 F. Supp. at 1319; Burns v. Vowell, 424 F. Supp. 1135, 1141 (S.D. Tex. 1976); Franssen v. Juras, supra, 406 F. Supp. at 1378. But see Norman v. St. Clair, supra, slip op. at 11-12.

In my opinion, § 1396a(a)(17)(D) authorizes states to enforce the financial responsibility of spouses (and parents) but not to authorize states to do so in a manner otherwise proscribed by the

statute. See Franssen v. Juras, supra, 406 F. Supp. at 1379. Under this statutory provision, the states are authorized to enforce their financial responsibility laws against spouses (and parents), where applicable, for medical expenses covered under Medicaid. If a state is one of the so-called "§ 209(b) states," as discussed further below, that state may enforce spousal financial responsibility either indirectly through its relative responsibility laws, if any, or directly through its Medicaid regulations. See Norman v. St. Clair, supra, slip op. at 11. However, if a state is an "SSI state," then the state may only enforce spousal financial responsibility through its Medicaid regulations to the extent permissible under the SSI statute. Any greater attempt to enforce spousal financial responsibility can only be effected through the state's relative responsibility laws, if any.

This construction of § 1396a(a)(17)(D) is not inconsistent with the legislative history. Referring to this statutory provision, the Senate Finance Committee report stated:

> The committee believes it is proper to expect spouses to support each other and parents to be held accountable for the support of their minor children and their blind or permanently disabled children even though 21 years of age or older. Such requirements for support may reasonably include the payment by such relative, if able, for medical care.

S. Rep. No. 414, supra (emphasis added). In my view, Congress did not intend to shield one spouse (or parents) from financial responsibility for the support of the other spouse (or minor children or adult blind or disabled children) simply because that spouse (or children) is covered by Medicaid. By comparison, Congress expressly precluded states from holding relatives other than spouses (or parents) financially responsible for medical expenses covered by Medicaid.

While "nothing in the statute or legislative history limits a state to enforcing this responsibility [of a spouse] only through the use of the state's relative responsibility law," slip op. at 12 (emphasis in original), a state cannot enforce its relative responsibility law in a manner which is otherwise inconsistent with federal statutes and regulations. E.g., Townsend v. Swank, 404 U.S. 282, 285 (1971); Rosado v. Wyman, 397 U.S. 397, 408 (1970) (AFDC). As will be discussed further below, in a SSI state, the extent and duration of deeming under Medicaid is limited by the statutory provisions and regulations of the Supplemental Security Income program, SSI, 42 U.S.C. § 1381 et seq. In my view, § 1396a(a)(17)(D) does not authorize states which link Medicaid eligibility directly to SSI eligibility (the "SSI-Medicaid link"), and are thereby required to use SSI eligibility requirements, to in effect impose an additional criterion for Medicaid eligibility. See Gray Panthers v. Secretary for HEW, supra, 461 F. Supp. at 321; Manfredi v. Maher, supra, 435 F. Supp. at 1112; Franssen v. Juras, supra, 406 F. Supp. at 1378.

Enforcement of Spousal Financial Responsibility

This analysis does not preclude the state from seeking some contribution from the noninstitutionalized spouse. Herweg v. Ray, supra, 443 F. Supp. at 1319-20. In fact, the prospect of a wealthy spouse abandoning an institutionalized spouse, thus evading his or her financial responsibility and "getting away with it" is something of a false issue. "Nothing in the [Social Security Act] precludes a state from exercising its financial responsibility laws . . . in cases of unwarranted neglect, where, for example, a wealthy individual refuses to support an institutionalized spouse, even though he or she would be financially able to do so." Manfredi v. Maher, supra, 435 F. Supp. at 1115 & n. 18. The following comment and response, published with the 1977 spousal financial responsibility regulations (42 C.F.R. § 448.3(b) (1977)), further supports the continued availability of state financial responsibility laws and actions brought thereunder to enforce spousal obligations to support, where appropriate:

> Comment: The proposed regulations are contrary to State laws specifying financial responsibility of relatives.
>
> Response: Federal law authorizes the establishment of Federal standards with respect to Medicaid eligibility determinations. However, the Medicaid statute [and regulations do] not preclude States from enacting laws of general applicability, specifying the responsibility of spouses and parents with respect to

retroactive recovery of the costs of medical assistance furnished by the State to eligible recipients.

42 Fed. Reg. 2686 (1977) (emphasis added).

Further, I note that the Medicaid statute, 42 U.S.C. § 1396a(a)(25), and regulations, 42 C.F.R. § 433.135, provide for determining and taking into consideration the legal liability of third parties to pay for Medicaid services. Although, in my opinion, this provision for third party liability was intended to encompass insurance liability rather than relative responsibility, I see no reason why relative responsibility, if applicable, could not be reached through this provision. For example, the state could bring a suit in state court under its relative responsibility law and obtain a support order. The support order could then be included among the economic resources of the Medicaid applicant or recipient in determining eligibility and state payment levels. However, the state may not withhold Medicaid benefits if the support payments will not be available to the Medicaid recipient within a reasonable time. 42 C.F.R. § 433.135(e)(2).

Medicaid Program - Historical Structure

At this point a brief history and description of the structure of the Medicaid program is necessary. Since the beginning of the Medicaid program in 1965, participating states were required to make all recipients of cash assistance eligible for Medicaid. A state was required to provide for "making medical assistance available to all

individuals receiving aid or assistance under any plan of the state approved under title I, X, XIV, or XVI, or part A of title IV, [the former categorical assistance programs; see discussion below] or with respect to whom supplemental security income benefits are being paid under title XVI [SSI] of this subchapter." 42 U.S.C. § 1396a(a)(10)(A). See generally 42 C.F.R. § 435.1. Before 1974, federally-assisted, state-administered welfare programs provided "cash assistance" to needy persons in four categories: (1) persons 65 or older (Title I, Old Age Assistance), (2) the blind (Title X, Aid to the Blind), (3) the disabled (Title XIV, Aid to the Premanently and Totally Disabled), and (4) certain types of families (Title IV-A, Aid to Families with Dependent Children or AFDC). At state option, cash assistance to the aged, blind and disabled could be made available under a consolidated program, Aid to the Aged, Blind and Disabled (former Title XVI).

Because an individual had to be both categorically related (that is, eligible as aged, blind, disabled or a member of a family with children deprived of the support of at least one parent) and financially eligible on the basis of income and resources, recipients of cash assistance under one of the four categorical assistance programs were termed the "categorically needy."

States could also elect to cover under Medicaid selected groups of individuals who were financially eligible for cash assistance but ineligible because of certain other requirements or who were financially eligible but did not wish to receive

cash assistance. For example, an individual may refuse SSI because it is welfare but accept Medicaid as medical assistance. Individuals covered under these optional coverage provisions were still considered "categorically needy" and were eligible for the same medical services provided under Medicaid to recipients of cash assistance.

States could limit Medicaid coverage to the "categorically needy" or could choose to extend Medicaid coverage to the aged, blind or disabled or members of families with dependent children who had too much income and/or resources to be eligible for cash assistance under the appropriate categorical assistance program but not enough for necessary medical care. Such individuals were termed the "medically needy." A state could use higher levels of income and resources to determine Medicaid eligibility than those used to determine eligibility for cash assistance. The state was required to deduct an applicant's incurred medical expenses from income in determining eligibility for Medicaid. Unlike eligibility for cash assistance, Medicaid eligibility under the "medically needy" coverage option did not depend solely upon the absolute amount of an individual's income. Thus, the "medically needy" are persons whose income is too low to meet their medical expenses but too high to qualify directly for cash assistance. E.g., Friedman v. Berger, supra, 547 F. 2d at 726. Because states would be covering more persons under the "medically needy" option, states were permitted to provide more limited medical services to the "medically needy" than those provided to the "categorically needy."

The "medically needy" Medicaid coverage option is not at issue in the present case. However, it should be noted that either an SSI state or a § 209(b) state may choose to cover the "medically needy" in addition to the mandatorily covered "categorically needy."

The 1972 Amendments

In 1972 the categorical assistance programs (except AFDC) were replaced by a new federal program (SSI) of caseh assistance for the aged, blind and disabled under a new Title XVI. Social Security Amendments of 1972, Act of Oct. 30, 1972, Publ L. No. 92-603, 86 Stat. 1381 (effective Jan. 1, 1974) (hereinafter the 1972 Amendments). The basic purpose of SSI was to assure a minimum level of income for persons who are aged, blind or disabled and without income and resources sufficient to maintain a standard of living at the established federal income level. 20 C.F.R. § 416.110. Federally administered and fully federally financed, SSI, effective January 1, 1974, replaced the previous, state-administered categorical assistance programs for the aged, blind and disabled in all jurisdictions except Puerto Rico, Guam and the Virgin Islands. 42 U.S.C. § 1381 et seq. (AFDC continued to be state-administered.) SSI established uniform, nationwide eligibility standards and financial requirements, expanded the definition of disability to include individuals under 18 and lessened the variations in levels of assistance from state to state.

Most individuals who had been receiving cash assistance under the previous, state-administered categorical assistance programs that had used more liberal eligibility requirements than SSI were considered to qualify for SSI for purposes of Medicaid coverage. In addition, states that had been making higher payments to individuals under the old categorical assistance programs were required to pay the difference between the higher benefit and the SSI benefit in the form of mandatory state supplements.

States could also pay optional state supplements. 42 U.S.C. § 1382e; 20 C.F.R. § 416.2001-.2090. When the SSI program, which is wholly federally financed, was implemented, the states were no longer required to pay part of the cash assistance benefits to the aged, blind or disabled (except for the mandatory state supplements). Congress encouraged the states to use the funds they had previously used to provide categorical assistance to the aged, blind or disabled to supplement SSI payments to the aged, blind or disabled in the form of "optional state supplements." See H.R. Rep. No. 92-231, 92d Cong., 2d Sess. (1971), reprinted in [1972] U.S. CODE CONG. & AD. NEWS 4989, 5185 (hereinafter H.R. Rep. No. 92-231). Congress later decided that the states could also provide Medicaid to individuals who receive optional state supplements. 42 C.F.R. § 435.230. By statutory definition, 42 U.S.C. § 1382e(a), optional state supplements are paid to individuals who receive SSI benefits or who would be eligible except for the level of their income to receive SSI benefits. Thus, the eligibility standards

for an optional state supplement are identical to SSI except for income. In practice, the optional state supplement program is more inclusive than SSI.

Because SSI financial eligibility requirements are more liberal than the financial eligibility requirements of many of the old categorical assistance programs, many more individuals now qualify for cash assistance.

> When Congress initially created SSI, it intended to require that all states provide Medicaid assistance automatically to all SSI recipients. Because this would have automatically resulted in a huge increase in the Medicaid rolls in the various states, and Congress feared that some states might opt out of the Medicaid program altogether, Congress added a provision which gave states the option of utilizing more restrictive [Medicaid] eligibility conditions. Under this provision, section 1902(f) of the [Social Security] Act, 42 U.S.C. § 1396a(f) [§ 209(b) of the 1972 Amendments], a state was permitted to use any financial eligibility condition [for Medicaid] which was no more restrictive than that in use under the state's January 1972 eligibility conditions for its categorical [assistance] programs.

Gray Panthers v. Secretary of HEW, supra, 461 F. Supp. at 321. Section 209(b) of the 1972 Amendments thus changed the basic Medicaid

coverage requirement: the states are no longer required to provide Medicaid to all cash assistance (SSI) recipients; under § 1396a(f) the states can choose to provide Medicaid to a more restricted group of cash assistance recipients defined by the state's 1972 categorical assistance eligibility requirements. See West v. Cole, 390 F. Supp. 91 (N.D. Miss. 1975).

In a § 209(b) state Medicaid eligibility is not dependent upon receipt of or eligibility for cash assistance (SSI benefits), but instead is determined with reference to a historical standard (which can be no more restrictive than the 1972 categorical assistance requirements). For example, in a § 209(b) state, a particular individual could receive SSI but not be eligible for Medicaid. (Such an individual could be eligible for Medicaid under a "spend-down" provision. 42 U.S.C. § 1396a(f); e.g., Friedman v. Berger, supra, 547 F.2d 724; see also H.R. Rep. No. 92-231, supra, at 5061.) In contrast, in an SSI state, an individual who receives SSI is automatically eligible for Medicaid. The same automatic Medicaid eligibility also follows if the individual is eligible for (but does not actually receive) SSI and the state has elected to provide Medicaid under one of the "optional categorically needy" programs, for example, for the institutionalized, in an SSI state. This is the SSI-Medicaid link discussed below.

Present Structure

Under the present structure of Medicaid, the states must provide Medicaid coverage to the "categorically needy" under one of two major options:

(1) to all SSI recipients or (2) to those cash assistance recipients who meet eligibility requirements more restrictive than those under SSI, but which are no more restrictive than the eligibility requirements in effect in January 1972 for the state's previous categorical assistance programs. 42 U.S.C. § 1396a(a)(10)(A), (f); 42 C.F.R. § 435.120,.121. Thirty-four states, including Iowa, and the District of Columbia have chosen to provide Medicaid coverage under the SSI option. These states are usually referred to as "SSI states." Fifteen states have chosen the other major option; these states may be referred to as "§ 1902(f) states" after the applicable section of the Social Security Act or "§ 209(b) states" after the applicable section of the 1972 Amendments or as "1972 option states" after the year designated as the historical standard. I will use the designation "§ 209(b) state."

States must also provide Medicaid coverage to AFDC recipients, recipients of mandatory state supplements, and to certain other groups of individuals who were eligible for Medicaid in 1973 under optional coverage provisions, such as "essential spouses" or individuals who were institutionalized in December 1973. 42 U.S.C. § 1396a(a)(10); 42 C.F.R. § 435.1(d)(4), .110(a), .130-.133. However, this mandatory Medicaid coverage is not at issue in the present case.

States may, as a matter of state option, choose to provide Medicaid coverage to certain other groups of individuals, the so-called "optional categorically needy." 42 U.S.C. § 1396a(a)(10)(C)(III); 42 C.F.R. § 435.200-.231. In general, these

individuals meet the eligibility requirements for cash assistance programs but do not actually receive cash payments or would be eligible for cash payments if they were not in medical institutions. This is the "gap" discussed by Judge Ross. Slip op. at 15. Because Medicaid coverage depends on receipt of cash assitance, 42 U.S.C. § 1396a (a)(10)(A), the classification "optional categorically needy" allows the states to selectively extend Medicaid coverage to individuals who are otherwise eligible to receive cash assistance but not actual recipients.

The "optional categorically needy" classification is also important because the Medicaid statute requires the states to provide Medicaid coverage to the "medically needy" if they choose to provide Medicaid coverage to individuals other than the "categorically needy." 42 U.S.C. § 1396a(a)(10)(C). (As discussed above, the "medically needy" are aged, blind or disabled individuals or certain families and children whose income and resources are too high to qualify as "categorically needy" but insufficient to meet their medical expenses.) The states may choose to extend Medicaid coverage to the "medically needy," but choosing to do so substantially increases the number of Medicaid eligibles and the cost. However, because the "optional categorically needy" are considered among the "categorically needy," the "optional categorically needy" classification enables states to evade this restriction and selectively extend Medicaid coverage to certain groups (such as the institutionalized) which they feel are the most in need of state help without having to provide Medicaid to the "medically needy." 42 U.S.C. § 1396a(a)(10)(C)(III).

The state of Iowa provides Medicaid to the "categorically needy" under the SSI option and to several groups of the "optional categorically needy," including the institutionalized under 42 C.F.R. § 435.211, .231, and recipients of optional state supplements under 42 C.F.R. § 435.230. Iowa does not provide Medicaid coverage to the "medically needy."

The SSI - Medicaid Link

As discussed above, in SSI states, SSI eligibility requirements are in effect Medicaid eligibility requirements because all SSI recipients are automatically eligible for Medicaid. 42 U.S.C. § 1396a(a)(10)(A). This is the SSI - Medicaid link: Medicaid eligibility is predicated upon SSI eligibility.

To be eligible for SSI, and individual must be categorically related (aged, blind or disabled) and financially eligible. The income and resources requirements an SSI applicant must satisfy depend in part on whether the applicant has a spouse, whether the applicant and such spouse (if any) are living in the same household and whether such spouse is an "eligible spouse." Congress evidently made these distinctions in order "to take account of the fact that two people living together can live more economically than they would if each lived alone." H.R. Rep. No. 92-231, supra, at 5136. Accordingly, Congress set the maximum SSI benefit payable to a married couple composed of two eligible individuals (an "eligible couple") (currently $312.30/month) lower than the combined maximum SSI benefit payable to two eligible individuals

(currently $208.20 x 2 = $416.40/month). (Comparable "single household" restrictions apply to children and parents.) The SSI definitions of "eligible individual" and "eligible spouse" and the treatment of separation and institutionalization under SSI, as discussed below, were drafted to take advantage of the economy of scale of a common household. See Franssen v. Juras, supra, 406 F. Supp. at 1378.

For the purposes of determining eligibility and the amount of benefits, the SSI statute expressly requires the deeming of income and resources from one spouse to the other spouse as long as they live together in the same household. 42 U.S.C. §§ 1382(a)(2), (b)(2); 1382c(f)(1). Deeming is mandated by the statutory definition of "eligible individual" when both spouses are aged, blind or disabled, 42 U.S.C. § 1382(a)(2), and by express statutory provision when only one spouse is aged, blind or disabled, 42 U.S.C. §1382c(f)(1).

Only "eligible individuals" are entitled to SSI benefits. 42 U.S.C. § 1381a. The statutory definition of "eligible individual" provides that

> (1) Each aged, blind or disabled individual who does not have an eligible spouse and --
>
> > (A) whose income, other than income excluded pursuant to section 1382a(b) of this title, is at a rate of not more than $1,752 (or, if greater, the amount determined under section 1382f of this title)

for the calendar year 1974, or any calendar year thereafter, and

(B) whose resources, other than resources excluded pursuant to section 1382b(a) of the title, are not more than (i) in case such individual has a spouse with whom he is living, $2,250, or (ii) in case such individual has no spouse with whom he is living, $1,500,

shall be an eligible individual for purposes of this subchapter.

(2) Each aged, blind, or disabled individual who has an eligible spouse and--

(A) whose income (together with the income of such spouse), other than income excluded pursuant to section 1382a(b) of this title, is at a rate of not more than $2,628 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974, or any calend calendar year thereafter, and

(B) whose resources (together with the resources of such spouse), other than resources excluded pursuant to section 1382b(a) of this title, are not more than $2,250,

shall be an eligible individual for purposes of this subchapter.

42 U.S.C. § 1382(a)(1), (2) (emphasis added). (Section 1382f provides for cost-of-living increases. The current maximum income level is $2498.40 for an individual who does not have an eligible spouse under § 1382(a)(1)(A) and $3,747.60 for an individual who soes have an eligible spouse under § 1382(a)(2)(A).) An "eligible spouse" is defined by the SSI statute as "an aged, blind or disabled individual who is the husband or wife of another aged, blind, or disabled individual and who has not been living apart from such other aged, blind, or disabled individual for more than six months." 42 U.S.C. § 1382c(b) (emphasis added).

Thus, in the case of a married couple composed of an "eligible individual" and an "eligible spouse" (that is, where both spouses are aged, blind or disabled), the applicant's income and resources are considered together with those of the eligible spouse in determining eligibility (for SSI). Deeming is required as well in determining the level of benefits:

> (2) The benefit under this subchapter for an individual who has an eligible spouse shall be payable at the rate of $2,628 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974 and any calendar year thereafter, reduced by the amount of income, not excluded pursuant to section 1382a(b) of this title, of such individual and spouse.

42 U.S.C. § 1382(b)(2) (emphasis added). (The maximum SSI benefit payable to such an eligible couple is currently $3,747.60.) The income and

resources of each spouse are deemed to be available to the other. This deeming will continue as long as they live together in the same household or until they have been living apart for six months. E.g., Mansfield v. Weinberger, 398 F. Supp. 965, 968-69 (D.D.C. 1975). (Because of the definition of "eligible spouse," a spouse is no longer an "eligible spouse" after a separation of six months.) In other words, if both spouses are aged, blind or disabled, the income and resources of one are deemed to be available to the other as long as they in fact share the same household or until they have been separated for six months.

In the case of a married couple composed of an eligible individual and an ineligible spouse, Congress recognized that such a couple theoretically enjoys a similar economy of scale as long as they maintain one household and expressly provided that

> [f]or purposes of determining eligibility for and the amount of benefits for any individual who is married and whose spouse is living with him in the same household but is not an eligible spouse, such individual's income and resources shall be deemed to include any income and resources of such spouse, whether or not available to such individual, except to the extent determined by the Secretary to be inequitable under the circumstances.

42 U.S.C. § 1382c(f)(1) (emphasis added). In other words, Congress required that where an eligible individual lives in the same household with

his or her ineligible spouse, then such eligible individual's income and resources shall include the income and resources of the ineligible spouse. (The actual computation of "deeming" is quite complex. See 20 C.F.R. § 416.1185 (deeming of income), .1202 (deeming of resources).) Deeming in the case of an eligible individual and ineligible spouse will continue as long as they live together in the same household. Thus, deeming stops in theory at the time such spouses no longer live together. However, any chang in living arrangements (such as separation) will not be recognized by the SSI administrative process until the beginning of the month after the month in which the change in living arrangements occurred. (Evidently changes in eligibility status are administratively cognizable only at monthly intervals. Although redetermination of eligibility and amount of benefits is required at least once every twelve months, 20 C.F.R. § 416.222, a basic change in eligibility status without loss of eligibility will be reflected in a redetermination of payment amount for each month within a quarter. 20 C.F.R. § 416.222.)

Couples may be separated by the institutionalization of one or both spouses. In the event one spouse (or both) is institutionalized, such spouses obviously no longer "live together in the same household." In making SSI eligibility determinations for spouses who are separated by institutionalization, the income and resources of one spouse are deemed to be available to the other spouse until the spouses have been separated for six months in the case of an eligible individual and eligible spouse or until the month after the month during which one spouse was institutionalized in the case of an eligible

individual and ineligible spouse.

In addition, the amount of SSI benefits changes when one spouse has been institutionalized for one month. 42 U.S.C. § 1382(e)(1)(B) provides:

> (B) In any case where an eligible individual or his eligible spouse (if any) is, throughout any month, in a hospital, extended care facility, nursing home, or intermediate care facility receiving payments (with respect to such individual or spouse) under a State plan approved under subchapter XIX of this chapter, the benefit under this subchapter for such individual for such month shall be payable--
>
> (i) at a rate not in excess of $300 per year (reduced by the amount of any income not excluded pursuant to section 1382a(b) of this title) in the case of an individual who does not have an eligible spouse;
>
> (ii) in the case of an individual who has an eligible spouse, if only one of them is in such a hospital, home of facility throughout such month, at a rate not in excess of the sum of--
>
> (I) the rate of $300 per year (reduced by the amount of any income, not excluded pursuant to section 1382a(b) of this title, of the one who is in such hospital, home, or facility), and

(II) the applicable rate specified in subsection (b)(1) [maximum individual benefit] (reduced by the amount of any income, not excluded pursuant to section 1382a(b) of this title, of the other) . . . .

Basically, the institutionalized spouse receives a much lower SSI benefit (maximum $25/month) and the noninstitutionalized spouse, if eligible, receives an SSI benefit at the rate applicable to an eligible individual (instead of half the rate applicable to an eligible couple). 42 U.S.C. § 1382(e)(1)(B)(i) (eligible individual who does not have an eligible spouse), (ii) (eligible individual who has an eligible spouse); 20 C.F.R. § 416.231.

In sum, under the SSI program, deeming is mandated by statute as long as the couple lives together in the same household. If the couple ceases to live together, deeming will cease at the beginning of the month after the month in which they cease to live together if only one spouse is aged, blind or disabled and after six months of separation if both spouses are aged, blind or disabled. (This difference in the duration of deeming is the result of the statutory definition of "eligible spouse" which sets a six month separation in part to discourage couples from living apart to collect more benefits.)

These periods of deeming should be familiar to the reader; they are precisely the periods of deeming specified in the Medicaid regulation at issue, 42 C.F.R. § 435.723. This congruence is not coincidental; it is compelled by the relationship

between the SSI and the Medicaid programs. This is because the Medicaid regulation at issue establishes spousal financial responsibility criteria that apply, in an SSI state, when determining the Medicaid eligibility of certain groups of individuals who, though not in fact eligible to receive SSI benefits, are identified by referring to SSI eligibility. For example, 42 C.F.R. § 435.723 applies to institutionalized individuals who would be eligible to receive SSI benefits if they were not institutionalized (42 C.F.R. § 435.211) and institutionalized individuals who, because of the level of their income, would not be eligible to receive SSI benefits even if they were not institutionalized, but whose income is below a specified level (42 C.F.R. § 435.231). The Medicaid eligibility of these institutionalized individuals depends upon their SSI eligibility, except for the level of their income.

Why is there a special exception for Medicaid eligibility for the institutionalized? As noted by Judge Ross, slip op. at 15-16, there is a "gap" in the Medicaid coverage of the institutionalized. This "gap" is the product of the interaction between two statutory provisions: 42 C.F.R. § 1396a(a)(10)(A), the part of the Medicaid statute which links Medicaid eligibility to the receipt of cash assistance, and 42 U.S.C. § 1382(a)(1)(B), the SSI statutory provision which sets the maximum SSI benefit payable to an institutionalized individual (technically, to an individual who is in a hospital, extended care facility, nursing home or intermediate care facility receiving Medicaid payments with respect to that individual's care) at the rate of $300/year ($25/month). See 20 C.F.R. § 416.231.

The SSI benefit level for the institutionalized was set at a maximum of $25/month because Congress anticipated that "most subsistence needs [of the institutionalized] are met by the institution [and paid for by Medicaid] and full benefits are not needed. Some payment to these people, though, would be needed to enable them to purchase small comfort items not supplied by the institution." H. R. Rep. No. 92-231, supra, at 5136. The $25/month maximum, which is reduced by nonexcluded income, sets a very restrictive income standard to determine eligibility for SSI benefits for the institutionalized. In practice, an institutionalized individual can receive up to $45/month in nonexcluded income before becoming ineligible for an SSI benefit. (There is a $20/month income disregard allowed under 42 U. S. C. § 1382a(b)(2)(A).)

For example, a majority of the institutionalized (that is, the elderly in nursing homes) receive some income, typically in the form of Title II Social Security benefits (Old Age, Survivors and Disability Insurance under § 201 of the Act, 42 U. S. C. § 401 et seq.). Because Title II benefits are nonexcluded income, see 42 U. S. C. § 1382a(a)(2)(B), (b), receipt of such benefits reduces the amount of the SSI benefit. If an institutionalized individual receives $30/month in Title II benefits, the amount of such individual's SSI benefit is $15/month ($25/month maximum SSI benefit reduced by $10, which is the $30/month Title II benefit less the $20/month income disregard). However, a Title II benefit of $45/month (or more) would reduce the SSI benefit to $0 ($25/month maximum SSI benefit reduced by $25, which is the $45/month Title II benefit less the $20/month income disregard).

What this means is that any insitutionalized individual who receives $45/month or more of nonexcluded income, which is a very small amount, is not eligible for SSI (technically, such an individual is not eligible to receive an SSI benefit) and thus loses his/her Medicaid eligibility. That individual has lost the SSI "link" to Medicaid eligibility.

Congress recognized the severe hardship this "gap" in Medicaid coverage imposed upon the institutionalized and amended the Medicaid statute in 1973. Act of Dec. 31, 1973 (Social Security Amendments of 1973), Publ L. No. 93-233, § 13(a)(3), 87 Stat. 960 (codified in 42 U.S.C. § 1396a(a)(10)(C)(III); 42 C.F.R. § 435.211,.231; see also 119 Cong. Rec. 43227 (remarks of Rep. Ullman). States may close the "gap" by extending Medicaid eligibility to institutionalized individuals who are ineligible for SSI (or AFDC or an optional state supplement under 42 C.F.R. § 435.230) because of the lower income standards used under those programs to determine eligibility for institutionalized individuals, but who would be eligible for SSI (or AFDC or an optional state supplement) if they were not institutionalized. 42 C.F.R. § 435.211. In addition, states may also extend Medicaid eligibility to institutionalized individual who are aged, blind or disabled and who, because of the level of their income, would not be eligible for SSI (or an optional state supplement) even if they were not institutionalized (income above $208.20/month for eligible individual who does not have an eligible spouse; income above $312.30 for eligible individual who has an eligible spouse), but whose income is below a certain level. 42 C.F.R. § 435.231,.1005 (maximum income standard

under § 435.231 is 300% of the maximum SSI individual benefit of $208.20/month or $624.60; the maximum income standard set by the state of Iowa under this section is currently $600/month, effective July 1, 1979).

The higher income standard permissible under § 435.231 presumably is a reflection of the extraordinary costs of institutional care. See 42 C.F.R. § 435, 722(a). Theoretically, the use of a higher income level for institutionalized individuals is based upon a fictitious optional state supplement where no benefits are actually paid or received by the institutionalized individual. See 42 U.S.C. § 1382e(e) (reduction of SSI benefit by amount of optional state supplement in case of institutionalized individual); H.R. Rep. No. 92-203, supra, at 5186 (optional state supplements based upon special needs).

In sum, Medicaid eligibility in an SSI state is premised upon SSI eligibility. Medicaid eligibles (except for AFDC recipients or individuals otyerwise eligible for AFDC or the medically needy) in an SSI state are either (1) SSI recipients; (2) optional state supplement recipients, who by definition are either SSI recipients or would be eligible for SSI except for the level of their income; (3) individuals who are eligible for SSI or an optional state supplement but who do not actually receive such benefits; (4) institutionalized individuals who would be eligible for SSI or an optional state supplement except for their institutional status; or (5) institutionalized individuals who would not be eligible for SSI or an optional state supplement because of the level of their income, even if they were not institutionalized, but whose income is

nonetheless below a certain level. The financial eligibility requirements of SSI or the optional state supplement program apply to those who are actually receiving those benefits; the Medicaid regulations at issue (42 C.F.R. § 435.700-.740) apply only to individuals who are not receiving actual benefits. 42 C.F.R. § 435.700.

Post-eligibility Treatment: Allocation of Income of Institutionalized Individuals Toward Cost-of-Care

It should be noted that 42 C.F.R. § 435.725 requires that the income of an institutionalized spouse in excess of a personal needs allowance ($25/month) (42 C.F.R. § 435.725(c)(1)) and a maintenance allowance for the support of the non-institutionalized spouse (42 C.F.R. § 435.725(c)(2)) or the family (42 C.F.R. § 435.725(c)(3)) be allocated toward the cost-of-care of the institutionalized spouse. In those cases where the institutionalized spouse is the source of most of the couple's or family's income, the allocation of patient income toward cost-of-care does impose significant hardships upon the noninstitutionalized spouse or family, who are thus constrained to live on a "maintenance allowance." The maintenance allowances are generally based on the income standards used to determine Medicaid eligibility and correspond to welfare subsistence levels. E.g., 42 C.F.R. § 435.725(c)(3)(iii) (maximum family maintenance allowance is state AFDC level or medically needy income standard). To this extent, appellants and Judge Ross, slip op. at 19, are accurate in observing that the "price" of Medicaid coverage for the institutionalized spouse is a rather frugal existence for the other spouse or family.

The allocation of income twoard cost-of-care equalizes the financial condition of the spouses and/or families of institutionalized Medicaid recipients. For example, because of the optional Medicaid coverage provisions, in particular 42 C.F.R. § 435.231, an institutionalized individual may be eligible for Medicaid even though his or her income greatly exceeds the maximum SSI financial eligibility level. In the absence of the allocation of income toward cost-of-care required by 42 C.F.R. § 435.725(c), the spouse or family of such an institutionalized individual who qualified for Medicaid under the higher income option would be much better off than the spouse or family of an institutionalized individual who qualified under the SSI income option (42 C.F.R. § 435.211). The "price" of Medicaid coverage for the institutionalized individual under the higher income option is that his or her spouse or family exists upon the income of the SSI spouse or family. In effect, the spouse or family pays for many thousands of dollars' worth of institutional care with the balance of the institutionalized individual's income above the spouse or family maintenance allowance.

Consider the following examples. I have drastically simplified the calculations. Further assume $200/month is the maximum individual SSI benefit and that the state has a higher income option standard for institutionalized individuals of $600/month under 42 C.F.R. § 435.231.

(1) A and B are married. No children.
A is disabled and institutionalized.
B is not aged, blind or disabled.
A has $600/month income.

B has no income

A just meets the higher income option standard.
A's allocation of income toward cost-of-care is $375. ($600 less $25 personal needs allowance less $200 maximum spouse allowance)

(2) Same facts except A has income of $400/month.

A meets the higher income option standard.
A's allocation toward cost-of-care is $175. ($400 less $25 personal needs allowance less $200 maximum spouse allowance)

(3) Same facts except A has income of $200/month.

A meets the SSI income option standard under 42 C.F.R. § 435.211.
A's allocation toward cost-of-care is 0. ($200 less $25 allowance less $200 maximum spouse allowance; B receives the $175 balance)

Thus, the allocation toward cost-of-care increases as the institutionalized individual's income exceeds the SSI income option level.

Moreover, Mr. Herweg's ineligibility for Medicaid, the "devastating result" described on page 19 of the slip opinion, is simply the consequence of an individual having too much income to qualify for Medicaid, even under the higher income option for the institutionalized. Mr. Herweg's gross monthly income ($1,350) exceeds the federal income maximum of $624.60 per month (300% of the maximum SSI individual benefit of $208.20). He is therefore ineligible for Medicaid under the higher income option for institutionalized individuals (42 C.F.R. § 435.231) and the optional state supplement (42 C.F.R. § 435.230) because of the level of his income. (Further, Mr. Herweg's net monthly income exceeds Iowa's maximum of $600 per month. After deduction of the $20 income exclusion and the earned income exclusion of $65 plus half the remaining amount, Mr. Herweg's net monthly income is $632.50) Such a result is really an argument in favor of the state electing to provide Medicaid to the medically needy, who by definition have medical expenses which exceed their income, or Congressional amendment of Title XIX to provide Medicaid to individuals, regardless of income, who suffer catastrophic illness and/or require institutional care. Quite frankly, the cost of institutional care is probably beyond the economic resources of all but the wealthiest individuals.

Medicaid Eligibility Determination of Elvina Herweg

Elvina Herweg is permanently and totally disabled and requires institutional care. It appears from the record that she has no independent income, such as a pension or Social Security benefits. Darrell Herweg is not aged, blind or disabled.

Elvina Herweg was institutionalized on November 1, 1976. Darrell Herweg applied for Medicaid on her behalf on January 20, 1977, long after the month in which they ceased to live together (November 1976). As of January 20, 1977, Elvina was eligible for the maximum $25/month SSI benefit for institutionalized individuals and, as an SSI recipient, eligible for Medicaid. As of December 1, 1976, the month after the month they ceased to live together, the state could not deem the income or resources of Darrell Herweg to be available to his wife.

However, if Darrell Herweg had submitted the Medicaid application on November 1, 1976, Elvina's income and resources for the purposes of determining Medicaid eligibility would have included Darrell Herweg's income and resources to the extent specified in the SSI deeming regulation, 20 C.F.R. § 416.1185, and Medicaid deeming regulation for SSI states, 42 C.F.R. § 435.723. The state would have made one Medicaid eligibility and allocation toward cost-of-care determination as of November 1, 1976, and a second as of December 1, 1976 (change in living arrangements).

I believe the SSI (and thus Medicaid) calculations for the first month (November 1976) would have been:

Darrell Herweg - gross income per month	$1,350.00
(SSI income defined in 20 C.F.R. § 416.1102(a); earned income refers to gross amount of wages under 20 C.F.R. § 404.429(c))	
Reduced by an allocation for each child under 21 and neither blind nor disabled - 3 children	-312.30
(amount of allocation is difference between SSI benefit rate for an individual and that for a couple; $312.30-$208.20 = $104.10) (20 C.F.R. § 416.1185(a)(1))	
	$1,037.70

Because this acount exceeds one-half of the SSI benefit rate for an eligible individual ($208.20 x 1/2 = $104.10), all of this amount is deemed to be available to Elvina Herweg. 20 C.F.R. § § 416.1185(a)(2), (3).

This amount is further reduced by appropriate income exclusions to determine "countable income." 20 C.F.R. § 416.1185(a)(3)(ii). "Countable income" is the amount of income used to determine an applicant's eligibility for SSI and, if eligible, the amount of benefits. 20 C.F.R. § 416.1115(a).

Balance	$1,037.70
Reduced by $20 income exclusion (20 C.F.R. § 416.1145(b)(9), .1165)	-20.00
Reduced by earned income exclusion ($65 plus half remaining amount; 20 C.F.R. § 416.1145(b)(10), .1167)	-541.35
	$476.35

Because this amount exceeds the SSI benefit payable to an eligible couple ($312.30), Elvina Herweg would not be eligible for SSI or Medicaid as of November 1, 1976, if the state only provided Medicaid to SSI recipients. 20 C.F.R. § 416.1185(a)(3)(iii).

However, Iowa has elected to use a higher income standard in the case of institutionalized individuals. 42 C.F.R. § 435.231. (The regulations technically require the higher income standard be applied effective with "the first full month of institutionalization," 42 C.F.R. § 435.722(c). Administratively, however, states are considered to be in compliance with the regulations if Medicaid eligibility is determined as of the day of institutionalization.) Under the higher income standard, a Medicaid applicant must in effect meet two income tests: (1) the applicant's gross monthly income must be below the federal income maximum of $624.60/month (300% of the maximum SSI individual benefit, $208.20) (42 C.F.R. § 435.1005), and (2) the applicant's net income (gross monthly

income less applicable SSI disregards) is less than Iowa's higher income standard of $600/month. 42 C.F.R. § 435.722(a), (b).

Because Elvina Herweg has no other income, her gross monthly income consists of the amount of income deemed to be available to her from her husband, $476.35, which is within the federal income maximum ($624.60). Deemed income is considered unearned income and is reduced by the $20 per month income exclusion (20 C.F.R. § 416.1165). Elvina's net income of $456.35 per month is less than Iowa's higher income standard of $600 per month. She would thus be eligible for Medicaid as of November 1, 1976.

Further, under 42 C.F.R. § 435.725, Elvina's allocation toward cost-of-care (client liability) would be $476.35 (total income) less $25.00 (minimum amount protected for an institutionalized individual), or $451.35. No additional allowances for maintenance of her husband or children would be made because maintenance allowances were already included in the deeming calculations under 20 C.F.R. § 435.1185.

Because deeming would have ceased as of December 1, 1976, Elvina's eligibility for SSI would have been redetermined as an individual as of December 1, 1976. She also would have been institutionalized for one month by that date. Because she has no other income, she would have easily qualified under the lower income standards for institutionalized individuals, $25/month reduced by nonexcluded income. (Even assuming she had some independent income, as long as her

gross monthly income was less than $624.60 and her net monthly income was less than $600, she would have been eligible for Medicaid in Iowa under the higher income option for institutionalized individuals.) Because Elvina has no income as of December 1, 1976 (deeming ceases), she has no income from which any allocation toward cost-of-care can be made. Her allocation toward cost-of-care is thus $0.

Income Exclusions

As noted by Judge Ross, slip op. at 17-18, I agree that Social Security benefits, Railroad Retirement Board annuities and Civil Service Commission annuities should be included as unearned income in determining SSI and Medicaid eligibility and amount of benefits. See 42 U.S.C. § 1382a(a)(2)(B); 20 C.F.R. § 416.1101(a) (income in general)., 1130 (types of periodic payments included in unearned income), .1146 (exclusions from income provided by other federal statutes), .1236 (exclusions from resources provided by other federal statutes).

Conclusion

I would hold that the state of Iowa as an SSI state cannot deem the income and resources of one spouse to be available to the other in making Medicaid eligibility determinations other than to the extent and for the duration specified in the applicable regulations, 42 C.F.R. § 435.700.725.

Chief Judge Lay, Judge Heaney, and Judge Stephenson concur in the result reached in Judge McMillian's opinion.

A true copy.

ATTEST:

CLERK, U.S. COURT OF APPEALS,
EIGHTH CIRCUIT.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF IOWA
CENTRAL DIVISION

FILED
JAN 19 1978

Clerk, U. S. District Court
Southern District of Iowa

ELVINA M. HERWEG, et al.,	)	
	)	CIVIL NO.
Plaintiffs,	)	77-222-1
	)	
vs.	)	MEMORANDUM
	)	OPINION AND
ROBERT D. RAY, et al.,	)	ORDER
	)	
Defendants.	)	

This is an action under 42 U. S. C. § 1983 seeking declaratory and injunctive relief pursuant to 28 U. S. C. §§ 2201 and 2202. Plaintiffs also seek class action certification pursuant to Federal Rules of Civil Procedure 23(a) and 23(b)(2). In substance plaintiffs ask this Court to declare Iowa Department of Social Services Manual Letter No. XII-1-28 pt. 2 dated June 3, 1977 invalid and to enjoin its enforcement. Such policy letter was authorized by House File 464, section 18, Acts of the 67th General Assembly of the State of Iowa. This letter contains a formula by which a portion of the income of a non-institutionalized spouse is "deemed" available to meet the needs of an

institutionalized spouse who receives Medicaid payments under Title 42 U.S.C. § 1396 et seq. Jurisdiction of the Court is proper under 28 U.S.C. § 1331 and 42 U.S.C. § 1343(3) and (4).

The State of Iowa has adopted and filed with the Department of Health, Education and Welfare (HEW) a plan for the implementation of Title XIX Medical Assistance programs, Iowa having chosen to participate in the Medicaid program. This state plan allegedly failed to comply with the statute and HEW regulations as set forth in 45 C.F.R. § 248.3(b). Defendant Burns, however, has indicated an intention to continue the procedure currently in effect.

Plaintiff Elvina Herweg is an adult resident of the State of Iowa who is permanently and totally disabled. The action is being pursued by her husband and next friend Darrell Herweg. She was born December 21, 1930 and is now 47 years of age. In August of 1976 she suffered aneurisms and cerebral hemmorrhaging on both the left and right sides and has since remained in a comatose state. Darrell Herweg applied for and received medical assistance for her hospital care on October 7, 1976. On January 20, 1977, he applied for Medicaid assistance for an extended care facility. Elvina Herweg had been placed in a skilled long-term facility on November 1, 1976.

At the time of filing this action Darrell Herweg was employed as a butcher for the Hinky Dinky supermarkets in Council Bluffs, Iowa, with a gross income of $1,350 per month ($1,032 net). He currently has three teenage daughters living

at home. Based on the original Department of Social Services (Department) calculations, he was required to contribute $234.80 per month towards his wife's care which total approximately $1,374 per month excluding fees of physicians and costs of medicine.

On June 2, 1977 the Department issued a Notice of Decision cancelling medical assistance for Elvina Herweg effective June 30, 1977 because under revised formula calculations well over one half of Darrell Herweg's income was "deemed" available for his wife's care, causing her "income" to be higher than the cut-off level. On June 7, 1977 Darrell Herweg appealed the decision to cancel assistance. The appeal hearing was held July 15 and on July 21, 1977 the original decision was affirmed. Subsequent to this Court's grant of a Temporary Restraining Order on July 28, 1977 the Department on August 11, 1977 issued a new "Proposed Decision" which modified the formula calculations for determining what portion of Darrell Herweg's income should be "deemed" available for Elvina Herweg's support as follows:

$ 1,350.00	gross monthly income
- 65.00	work expenses
1,285.00	÷ 2 equals 642.50
$ 642.50	
- 177.80	living allowance for non-institutionalized spouse
$ 464.70	
- 269.40	living allowance for three dependents computed at 89.80 for each of the three dependents

$	195.30	deemed to be Elvina Herweg's income from Darrell Herweg
-	20.00	disregard of income (Elvina Herweg's income)
$	175.30	
-	25.00	personal needs for spouse in
$	150.30	institution

Under this formula Darrell Herweg is required to provide $150.30 per month toward the total expenses of his wife's institutionalization. If he does not, eviction would be imminent.

Plaintiff's specific contentions are as follows:

1. The "deeming" practices ultilized by defendants pursuant to House File 464, section 18 violate the applicable implementing regulations, 45 C.F.R. § 248.3(b) which require that no deeming or attribution of income occur subsequent to the end of the first calendar month after one spouse enters the institution.

2. The deeming procedures violate the Medicaid statute, 42 U.S.C. § 1396a(a)(17) which requires that: (a) a state have reasonable standards for determining Medicaid assistance; (b) that such plan must provide that only income and resources actually available to the Medicaid recipient be considered; (c) that income and resources be reasonably evaluated; and (d) that the State take into account for purposes of determining appropriate payment from the non-institutionalized spouse, income only of those relatives legally responsible for her support.

3. The practice and concept of "deeming" create an irrebuttable presumption that the non-institutionalized spouse is capable of paying the amount computed by the formula set forth in the manual and that such amount is actually available. Such irrebuttable presumptions are not rationally related to a legitimate state interest and are accordingly violative of the Due Process Clause of the Fifth Amendment to the United States Constitution.

4. The imposition of an additional eligibility requirement on otherwise qualified Medicaid recipients (the payment of a "deemed" available amount) creates two classes of Medicaid recipients. One class consists of unmarried institutionalized Medicaid recipients, the other, married institutionalized Medicaid recipients. Disparate treatment between such classes is irrational and capricious thus violating the Equal Protection Clause of the Fourteenth Amendment.

Medicaid is a federally sponsored welfare program designed to provide medical benefits to those with limited incomes and resources. The overall purpose is to provide a "coordinated approach for health insurance and medical care for the aged under the Social Security Act". See 1 U.S. Code Cong. & Ad. News 1943 (89th Cong. 1st Sess. 1965). See generally 42 U.S.C. §§ 1396 et seq. In order to qualify for medical assistance, individuals must be within eligibility limits for approved categorical assistance programs such as Title XVI (Supplemental Security Income), Title IV-A (Aid for Families with Dependent Children) or a state supplemental payment

plan, either before or after medical expenses are taken into account. 42 U.S.C. §§ 1396(a)(10), 1396a(f); 45 C.F.R. § 248; Manfredi v. Maher, 435 F. Supp. 1106, 1108 (D. Conn. 1977).

Federal law places certain limitations upon the eligibility criteria which States may impose under Medicaid plans. See Manfredi v. Maher, supra; Burns v. Vowell, 424 F. Supp. 1135, 1138 (S.D. Tex. 1976) (limited to preliminary injunction consideration only); Franssen v. Juras, 406 F. Supp. 1375 (D. Ore. 1975).

The precise issue is whether the State's method of computing the income available under the circumstances is in conflict with the statute and departmental regulations. Plaintiffs claim that

> [t]his bureaucratic determination that income is available fails to consider the real contours of the situation; by imputing income to the institutionalized spouse (or, actually, to the institution which provides the care), the state ignores the fixed costs of the non-institutionalized spouse, thus forcing an impossible choice. If the non-institutionalized spouse does not make all of the payments in an effort to maintain his or her own standard, then that spouse runs the serious risk that the nursing home, which is necessarily only receiving a portion of the cost of care, will evict the institutionalized spouse.

THE STATUTE

Title 42 U.S.C. § 1396a(a)(17) provides in its pertinent parts:

> (a) A State plan for medical assistance must--
>
> . . . .
>
> (17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, . . .) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient . . . . (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 . . . . (Emphasis supplied)

The voluminous legislative history indicates that the provisions of 42 U.S.C. § 1396(a)(17) were "designed so that the States will not assume the availability of income which may not, in fact, be available". (Emphasis supplied) S. Rep. 404,

1 U.S. Code Cong. & Ad. News, supra at 2018. The same report further provides:

> The Committee has heard of hardships on certain individuals by requiring them to provide support and to pay for the medical care needed by relatives. The Committee believes it is proper to expect spouses to support each other and parents to be held accountable for the support of their minor children and their blind or permanently and totally disabled children even though 21 years of age or older. Such requirements for support may reasonably include the payment by such relatives, if able, for medical care. (Emphasis supplied)

Id. See Manfredi v. Maher, supra; Burns v. Vowell, 424 F. Supp. 1135, 1140-41 (S.D. Tex. 1976).

This Court joins other courts in holding that state procedures which "deem" a computed portion of a spouse's income to be available for an institutionalized spouse's expenses by the application of an arbitrary formula is contrary to 42 U.S.C. § 1396a(a)(17) as shown by its language and the expressed Congressional intent. Manfredi v. Maher, supra; Burns v. Vowell, supra; and Franssen v. Juras, supra.

This does not mean that the state may not seek some contribution from the non-institutionalized spouse. Congress has recognized that such spouse should be responsible for that portion

of an institutionalized spouse's expenses that he or she in fact is able to bear.

In Franssen v. Juras, supra, 406 F. Supp. at 1378 the Court said:

> Congressional purpose to calculate need with real rather than presumed dollars is evident from the report of the House Ways and Means Committee that accompanied the Medicaid bill.
> [quoting]
>
> Nonetheless, this prohibition against assuming sources of income is not intended to permit one spouse to spurn a normal obligation to support and assist the other merely by refusing to make contributions.

The Court took a similar position in Burns v. Vowell, 424 F. Supp. at 1141:

> Thus, while the income of a non-institutionalized spouse can be considered, it must be done through the application of reasonable standards and not on the basis of an irrebutable presumption that the money is available for the care and support of the institutionalized spouse. Deeming as employed by the Texas regulation is not consistent with the federal statutes and reguations, and cannot be employed to impute income. Thus where nursing home care is made available to eligible recipients, their spouses cannot 'be held accountable beyond their means'.

Although the operation of the State's formula as finally computed appears to make a reasonable allocation of income in the situation before the Court, it would seem to be merely coincidental. There has been no factual determination that this particular amount is reasonably available for the institutionalized spouse. In the Court's opinion, the state procedure must provide for a factual determination in each instance of the amount of the spouse's income which is in fact reasonably available for the support of the institutionalized spouse. Otherwise the procedures will be in conflict with 42 U.S.C. § 1396a(a)(17). Such determination must give due consideration to the individual obligations and the particular needs of each spouse and family.

The Court concludes that the Iowa Department of Social Services Manual Letter No. XII-1-28 pt 2 dated June 3, 1977 is invalid.

REGULATIONS

Section 248.3(b), Code of Federal Regulations, effective January 13, 1977, provides in part:

> (b) with respect to both the categorically needy and if they are included in the plan, the medically needy, a State plan must:
>
> (a) (ii) Where only one spouse applies as aged, blind or disabled or is SSI eligible, and they cease to live together in a common household, only actually contributed income and resources

> may be considered available in determining the eligibility or amount of assistance of the applicant or recipient after the month during which they cease to live together. (Emphasis supplied)

Griswold v. Page, TCA 77-712 (N.D. Fla. filed May 20, 1977) states:

> All parties to this action concede that these regulations proscribe the deeming procedures outlined above.
> 14. HRS has revised its field manual to reflect and comply with the changes in the federal regulations. Effective for the period beginning May 1, 1977, the income of a non-institutionalized spouse will no longer be imputed to be available to defray the expenses of the institutionalized spouse once a thirty-day period has elapsed from the initial date of institutionalization.

As the Court has already held that the state procedures are contrary to the statute, it must and does hold that the procedures are also contrary to regulations which arbitrarily refuse to impute the income of a non-institutionalized spouse to defray expenses of an institutionalized spouse.

As the arbitrary denial of any right for the states to make a factual determination of a reasonable amount of a non-institutionalized spouse's income which may be imputed to the institutionalized spouse appears to be contrary to statements in this opinion and the cited cases, the Court feels compelled to make it clear that this decision should not be

interpreted as approving the amended regulations. Mr. Califano and HEW are not represented in this action and it is therefore not appropriate to make a finding on the validity of that section. However, it seems to the Court that "deeming" is contrary to congressional intent whether income of the non-institutionalized spouse is deemed available or unavailable.

A state should be allowed under the statute to require proof of actual expenses, deducting those amounts from gross income to determine the amount, if any, that might reasonably be required as a contribution to the support of the institutionalized spouse. This approach would appear decidedly more flexible and equitable in its overall operation and furtherance of congressional intent.

The Court does not consider it necessary or proper to consider the plaintiffs claims relative to the unconstitutionality of the state's deeming procedures. However, one issue does remain, that of plaintiffs' class action request. Since defendants have stipulated to this action being proper for class action procedures, the Court accepts plaintiffs' contention that the proper class pursuant to Fed. R. Civ. P. 23(a) and (b)(2) consists of all married couples residing in Iowa of which: (1) one spouse is eligible for Medicaid and requires institutionalization; and (2) the other spouse is not institutionalized; and (3) the non-institutionalized spouse has income which is, under current state procedures, being deemed available to the institutionalized spouse. If the parties are unable to agree upon the proper notice and notice

procedures to be utilized, the Court will consider that issue at a later date.

IT IS THEREFORE ORDERED that plaintiffs' request for class action certification shall be, and the same is hereby granted.

IT IS FURTHER ORDERED that the plaintiffs' request for final determination, which the Court elects to treat as a motion for summary judgment shall be, and the same is hereby granted.

IT IS FURTHER ORDERED that plaintiffs' request for a permanent injunction against state "deeming" procedures shall be, and the same is hereby granted.

IT IS FURTHER ORDERED that any other matters not disposed of in this opinion and Order will be considered upon application of a party or parties.

Plaintiffs shall prepare a Judgment Entry in accordance herewith, obtain defendants approval as to form and submit it to this Court for signature.

Costs of this action are assessed against the defendants.

Signed this 19 day of January, 1978.

s/_____
W. C. Stuart, Chief Judge
Southern District of Iowa

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF IOWA
CENTRAL DIVISION

FILED
JUL 10 1978

Clerk, U. S. District Court
Southern District of Iowa

ELVINA M. HERWEG, et al., Plaintiffs, vs. ROBERT D. RAY, et al., Defendants.	CIVIL NO. 77-222-1 RULING AND ORDER

On January 19, 1978 this Court entered a Memorandum Opinion and Order which granted plaintiffs' request for class certification, their motion for summary judgment and their request for a permanent injunction against state "deeming" procedures. Herweg v. Ray, 443 F. Supp. 1313 (S.D. Iowa 1978). On March 17, 1978 plaintiffs filed a request with this Court seeking an Order which would set forth specifically the contours of relief to which plaintiffs were entitled. Defendants joined in this motion on March 22, 1978 and at the same time filed a brief which argued against retroactive application of the Court's affirmative relief set forth in the January 19, 1978 Order. Plaintiffs responded on March 31, 1978 and the

matter came on for hearing on April 27, 1978. Appearing for plaintiffs were Gill Deford and Robert Bray. Appearing for defendant was Stephen Robinson. Supplemental briefs were filed May 10 and June 27 by plaintiffs and defendants respectively. The Court now considers the matter fully submitted.

Three primary issues remain to be resolved: (1) the contents of the class notice; (2) the question of retroactive application of the Court's original ruling; and (3) the sufficiency of defendant's modified procedures pursuant to the statutes and this Court's Order. These issues will be discussed in inverse order.

Proposed revised procedures of the State Department of Social Services provide generally for disregarding of certain income and for the individualized determination of the amount of a non-institutionalized spouse's income which is in fact reasonably available for the support of the institutionalized spouse. Plaintiffs contend that adequate provision is not made for the disregarding of Social Security benefits, 42 U.S.C. § 407, Railroad Retirement Board annuities, 45 U.S.C. § 231m, and Civil Service Commission annuities, 5 U.S.C. § 8346(a). Plaintiffs also claim "the strong possibility remains, given the bland nature of these instructions, that workers will simply use the work sheet as their format and not bother to determine whether other expenses could be deducted".

The Court agrees that the three specific items noted above should be specifically mentioned in the revised State procedures. With this exception, the

procedures are satisfactory. The comment to section 4(e) provides "[t]he items listed are not intended to be all inclusive or in any way a limitation". The Department of Social Services employs trained individuals who, in cooperation with affected individuals, make independent determinations of income and expense items. The Court will not assume that certain items of income, properly exempt under various federal provisions, will be included as income or that proper expenses will not be allowed. Should either event occur proper procedures are certainly available within the administration of the Department of Social Services without detailed and continual federal court supervision.

Plaintiffs major dispute with the revised procedures concerns what is perceived by them to be continued "deeming" of income to be available from the non-institutionalized spouse for the institutionalized spouse's care. Plaintiffs take issue with revised procedures which, as an initial premise, combine incomes of the institutionalized and non-institutionalized spouse and, only after such combination has been made, make provision for the reasonable requirements of the non-institutionalized spouse. Plaintiff argues that any available income of the non-institutionalized spouse cannot automatically be "deemed" available unless it is actually contributed and that contribution can be compelled only through relative responsibility laws which would place the burden to pay on the non-institutionalized spouse without jeopardizing the qualification status of the institutionalized spouse.

The Court disagrees with the plaintiffs. Although such a procedure might be possible under the relevant statutes, the State has undertaken the responsibility of formulating a plan that also complies with the applicable statutes. The existence of alternative procedures is irrelevant. Title 42 U.S.C. § 1396a(a) provides:

> A State plan for medical assistance must--(17) include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and . . . (C) provide for reasonable evaluation of any such income or resources . . .

In the Court's opinion the proposed State plan involved herein adequately fulfills these objectives. In its original Order this Court recognized that, although a State may not "deem" income to be available by use of an arbitrary formula, this does not mean that the State may not seek some contribution from the non-institutionalized spouse. Further this Court recognized, although it could not specially find, that deeming is contrary to Congressional intent regardless of whether income is deemed to be available or not available. The proposed plan here is, in this Court's opinion, entirely consistent with the federal law. Plaintiffs' interpretation, while

perhaps consistent as well, is not mandatory and does not invalidate the State plan.

The Court is of the opinion that the January 19, 1978 Order is properly retroactive to the date of the filing of the original complaint, July 28, 1977.

The form of notice to be sent to the plaintiff class, attached hereto as Exhibit A, is consistent with that approved by the Seventh Circuit in Jordon v. Trainor, 563 F.2d 873 (7th Cir. 1977), cert. granted, sub nom. Quern v. Jordan, No. 77-841, 46 U.S.L.W. 3541 (February 28, 1978). As that Court said:

> No judgment for any award of damages against the state comes from the federal court. The members of the class will be given no more by the proposed modified notice that what they would have gathered by sitting in the courtroom or by reading and listening to news accounts had the case attracted attention. As for the state, our decision means only that if an appeal be filed in the future by a class member, the state may determine for itself by its own procedures whether any back payment may be due the applicant.

Jordan v. Trainer, supra at 878. The case is even more clear here where any retroactive recovery to any member of the plaintiff class would amount only to reimbursement of payments improperly demanded rather than payment of amounts improperly withheld or actual damages to be

recovered. The Court hereby specifically approves the class notice attached.

IT IS THEREFORE ORDERED that the proposed manual letter submitted by defendants at hearing shall be, and the same is hereby specifically approved, except that it must specifically point out that Social Security benefits, Railroad Retirement Board annuities and Civil Service Commission annuities are to be disregarded.

IT IS FURTHER ORDERED that the Order of this Court dated January 19, 1978 shall be, and the same is hereby declared to be retroactive to July 28, 1977.

IT IS FURTHER ORDERED that the parties shall have ten (10) days from the date of this Order to submit objections, if any, to the class notice attached hereto. If no objections are filed, this notice shall be sent to all members of the class as expeditiously as possible.

Signed this 10 day of July, 1978.

s/ _____
W. C. Stuart, Chief Judge
Southern District of Iowa.

CLASS NOTICE

To all married couples residing in Iowa of which: (1) one spouse is eligible for Medicaid and requires institutionalization; and (2) the other spouse is not institutionalized; and (3) the non-institutionalized spouse has income which is, under [previous] state procedures, being deemed available to the institutionalized spouse.

Notice of Possible Eligibility to Recover Amounts Previously Paid to the Iowa Department of Social Services.

On January 19, 1978 the federal district Court for the Southern District of Iowa declared that the Iowa Department of Social Services was in violation of federal law by its method of computing the amount of income which a non-institutionalized spouse was required to contribute towards the care of an institutionalized spouse under the Medicaid program. The Iowa Department of Social Services was directed to modify its computation procedures as follows: "The State procedure must provide for a factual determination in each instance of the amount of the spouse's income which is in fact reasonably available for the support of the institutionalized spouse." The Iowa Department of Social Services has not modified its procedure in compliance with the Court's Order.

According to our records, you are a member of the class in whose behalf this case was brought. In accordance with the Court's Order the Department is under an obligation to return to you any amounts over and above those which would have represented a reasonable contribution to your spouse's care and which you would have been able

to contribute at a given time in the past. The Department must now compute your reasonable past contribution, and once that figure is reached, it can be determined whether or not you will be eligible to have any amount returned to you. You should contact your local office of the Department of Social Services to arrange for a determination of the amount which would have represented an appropriate contribution to your spouse's care in the past. If the Department determines that you are not eligible to be reimbursed, or if you disagree with the amount which they reach, you will, of course, have the right to appeal that decision in the normal manner.

Although you are under no obligation to take any action in response to this letter, it is to your benefit to do so. In the event it is determined that the originally computed amount was less than that you could reasonably have been expected to pay under the modified method of computation, you will not be required to make up the difference. On the other hand, if the Department previously required you to pay an amount greater than that determined under the modified method of computation you will be refunded the difference. You should contact your local office of the Department of Social Services to arrange for a determination of the amount you could have been expected to contribute under the modified method of computation.

If you have any questions about this letter or the procedure it outlines, you should contact the Department of Social Services, your own attorney, or your nearest legal aid or legal assistance office.

Victor Preisser, Commissioner of
the Iowa Department of Social Services.

APPENDIX D

JUDGMENT ON DECISION BY THE COURT

UNITED STATES DISTRICT COURT
FOR THE
SOUTHERN DISTRICT OF IOWA--
CENTRAL DIVISION

Civil Action File No.

Elvina M. Herweg, by her husband and next friend, Darrell E. Herweg; and Darrell E. Herweg, and all others similarly situated	) FINAL) JUDGMENT
vs.	
Robert D. Ray, individually and in his capacity as Governor of the State of Iowa, et al	

This action came on for xxxx(hearing) before the Court, Honorable W. C. Stuart, United States District Judge, presiding, and the issues having been duly (heard) and a decision having been duly rendered,

It is Ordered and Adjudged that plaintiffs' request for class action certification is granted;

It is Further Ordered and Adjudged that plaintiffs' request for final determination has been treated by the Court as a motion for Summary Judgment and same is granted;

It is Further Ordered and Adjuged that plaintiffs' request for a permanent injunction against state "deeming" procedures is granted;

It is Further Ordered and Adjudged that any other matters not disposed of in the Opinion and Order will be considered upon application of a party or parties:

It is Further Ordered and Adjudged that that the Class Notice attached as Exhibit "A" to the Ruling and Order of July 10, 1978, shall be sent to all members of the class as expeditiously as possible.

It is Further Ordered and Adjudged that costs of this action incurred since the Bill of Costs filed February 15, 1978, are assessed against defendants.

Dated at Des Moines, Iowa, this 4th of August, 1978.

FILED
AUG 4 1978

Clerk, U. S. District Court
Southern District of Iowa

s/_____
Clerk of Court

APPENDIX E

United States Court of Appeals
FOR THE EIGHTH CIRCUIT

No. 78-1664

Elvina M. Herweg, by her husband and next friend, Darrell E. Herweg, and Darrell E. Herweg, and all others similarly situated,	*
Appellants,	* Appeal from the United States District Court for the Southern District of Iowa.
v.	
Robert D. Ray, individually and in his capacity as Governor of the State of Iowa, and Kevin J. Burns, individually and in his capacity as Commissioner of the Iowa Department of Social Services,	*
Appellees.	*

Filed: April 22, 1980

Before LAY, Chief Judge, HEANEY, BRIGHT, ROSS, STEPHENSON, HENLEY, McMILLIAN, ARNOLD, Circuit Judges, and GIBSON,* Senior Circuit Judge.

---

* The Honorable Floyd R. Gibson was Chief Judge of the Eighth Circuit at the time this case was submitted and took senior status on December 31, 1979.

ORDER ON PETITION FOR REHEARING

The petition for rehearing is denied.

A true copy.

ATTEST:

CLERK, U. S. COURT OF
APPEALS, EIGHTH CIRCUIT.

APPENDIX F

1) 42 U.S.C. § 1396a(a)(10):

"A State plan for medical assistance must--

...

(10) provide--

(A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter;

(B) that the medical assistance made available to any individual described in clause (A)--

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in Clause A; and

(C) if medical assistance is included for any group of individuals who are not described in Clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income

program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary--

(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under subchapter XVI of this chapter, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1396d(a) of this title to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of subchapter XVIII of this chapter to individuals eligible therefor (either pursuant to an agreement entered into under section 1395v of this title or by reason of the payment of

premiums under such subchapter by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of subchapter XVIII of this chapter for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, and (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary, with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A);"

2) 42 U.S.C. § 1396a(a)(17):

"A State plan for medical assistance must--

. . .

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in

the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State

program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;"

3) 42 U.S.C. § 1396a(f):

"(f) Notwithstanding any other provision of this subchapter, except as provided in subsection (e) of this section, no State not eligible to participate in the State plan program established under subchapter XVI of this chapter shall be required to provide medical assistance to any aged, blind, or disabled invididual (within the meaning of subchapter XVI of this chapter) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such

individual as determined in accordance with section 1396b(f) of this title (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to clause (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under clause (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under clause (10)(A), or (2) an eligible individual or eligible spouse, as defined in subchapter XVI of this chapter, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under clause (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to clause (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from

income shall be considered an individual eligible for medical assistance under clause (10)(A) of that subsection."

4) 42 C.F.R. § 435.723:

"Financial responsibility of spouses.

(a) If the agency provides medicaid to SSI recipients, it must meet the requirements of this section in determiing eligibility of aged, blind, and disabled individuals under the optional coverage provisions of §§ 435.210, 435.211, and 435.231.

(b) The agency must consider income and resources of spouses living in the same household as available to each other, whether or not they are actually contributed.

(c) If both spouses apply or are eligible as aged, blind, or disabled and cease to live together, the agency must consider their income and resources as available to each other for the first 6 months after the month they cease to live together. After this 6-month period, the agency must consider only the income and resources that are actually contributed by one spouse to the other.

(d) If only one spouse in a couple applies or is eligible and they cease to live together, the agency must consider only the income and resources of the eligible spouse that are actually contributed to the eligible spouse after the month in which they cease to live together."

Supreme Court, U. S.
FILED
AUG 27 1980
MICHAEL RODAK, JR., CLERK

No. 80-60

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1980

ELVINA M. HERWEG, by her husband and next friend, Darrell E. Herweg; and DARRELL E. HERWEG, on behalf of themselves and all others similarly situated,

Petitioners,

vs.

ROBERT D. RAY, individually and in his capacity as Governor of the State of Iowa; and KEVIN J. BURNS, individually and in his capacity as Commissioner of the Iowa Department of Social Services,

Respondents.

SUPPLEMENTAL BRIEF OF PETITIONERS IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

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No. 80-60

IN THE
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Argument

A RECENT DECISION OF THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT SPECIFICALLY SUPPORTS PETITIONERS' POSITION THAT THE "SSI STATES" ARE LOCKED INTO THE ELIGIBILITY CONDITIONS OF THE SUPPLEMENTAL SECURITY INCOME PROGRAM FOR THE PURPOSE OF DETERMINING MEDICAID ELIGIBILITY FOR THE AGED, BLIND AND DISABLED

The issue presented by this petition is whether the Department of Health and Human Services ("HHS") has properly interpreted the Medicaid statute to require the so-called "SSI states" to employ the conditions and rules of the Supplemental Security Income ("SSI") program in making Medicaid eligibility determinations. The Eighth Circuit, in a split decision affirming the district court, invalidated HHS regulations which had implemented the appropriate SSI rules for evaluating the availability of income and resources to an institutionalized individual from his or her non-institutionalized spouse. These rules, which forbid the SSI states from deeming income and resources available for more than one or six months, depending on the eligibility of the non-institutionalized spouse, had been applied to the 35 SSI states, of which Iowa was one. The district court and the Eighth Circuit upheld Iowa's explicit determination not to follow these requirements.

Petitioners have argued that affirmance of the district court violated the requirements of the Medicaid and SSI statutes, 42 U.S.C. §§1396, et seq. and 1382, et seq., respectively, and directly contradicted the understanding of every court which had previously considered the relationship between those statutes in the SSI states. See Petition, at 19-21 &nn. 11-17. Respondents have offered nothing in their Opposition to which Petitioners have not already responded, but since the filing of the Petition, another court has announced a decision which carefully describes the nature of the integration between the SSI and Medicaid statutes in the SSI states, thereby requiring this Supplemental Brief.

That decision has affirmed the district court invalidation of the HHS deeming regulations applicable to the 209(b) states. Gray Panthers v. Administrator, Health Care Financing Administration, Department of Health and Human Services, No. 79-1334 (D.C. Cir., July 29, 1980) aff'g sub nom. Gray Panthers v. Secretary, Department of Health, Education and Welfare, 461 F.Supp. 319 (D.D.C. 1978).[1/] Petitioners noted that the district court in that case had recognized that the SSI states are required to use the SSI rules in determining Medicaid eligibility, Petition, at 20 & n. 15; but the Court of Appeals' decision sets out in significant detail the relevant difference between 209(b) and SSI states.

[1/] The Court of Appeals opinion is reported at CCH Medicare & Medicaid Guide, par. 30,588. Citations in this brief will be to both the Slip Opinion and the CCH Medicare & Medicaid Guide.

The majority opinion by Chief Judge Wright begins by explaining the nature of the Medicaid program, with particular emphasis on the 209(b) option and its purposes. In setting out the nature of that option, the court directly supports Petitioners' position:

> "42 U.S.C. §1396a(a) provides that Medicaid assistance must be made available to all individuals who qualify for cash benefits under the Supplemental Security Income (SSI) program, Title XVI of the Social Security Act, 42 U.S.C. §1381, et seq. (1976). In these 'SSI states' Medicaid eligibility is determined by statute in accordance with uniform federal standards." Gray Panthers v. Administrator, supra, Slip Op., at 4; CCH Medicare & Medicaid Guide, par. 30,588 at p. 10,415.

Applying these principles specifically in the deeming context, the court outlines, as did Judge McMillian in his opinion below, how deeming was established and limited by the SSI statute in the SSI states. The court acknowledges that deeming is permissible between spouses living together, and then describes how the rules differ when they separate:

> "Where both spouses are otherwise eligible for Medicaid, and one spouse is institutionalized, the pooling of funds continues for six months. The effect of this scheme is thus to 'deem' a portion of the noninstitutionalized

> individual's income and resources to be available for support of his or her spouse. After six months of institutionalization only the income and resources of the institutionalized spouse are considered for determining eligibility, and the 'deeming' ceases. 42 U.S.C. §1382c(b). Where only one of the spouses is otherwise Medicaid-eligible, pooling of income must cease with the first month of institutionalization. 42 U.S.C. §1382c(f)." Id., at 6; CCH Medicare & Medicaid Guide, par. 30,588, at p. 10,416 (footnote omitted).

Finally, the court considers the government's claim that as Medicaid deeming is permitted in the SSI states on a limited basis, it must also be proper in the 209(b) states. Recognizing that the purpose of the six-month pooling of income and resources after separation for determining SSI eligibility was exclusively to deter fraud, id., at 9, CCH Medicare & Medicaid Guide, par. 30,588, at p. 10,417,[2/] the court rejects any intimation that deeming in the SSI states is relevant to deeming in the 209(b) states. In so doing, it once again underlines the requirement that the SSI states follow the SSI eligibility conditions:

> "We do not believe the statutorily required 'deeming' in SSI states should

---

2/ See Petition, at 28 n. 23.

be given such dispositive weight with respect to 209(b) jurisdictions. We perceive the governing principle in SSI states to be that the institutionalized individual is to be held solely responsible for his or her own medical care, with 'deeming' a very narrow exception. See 42 U.S.C. §1382(a)(1)." Id., at 9; CCH Medicare & Medicaid Guide, par. 30,588 at p. 10,417. (Emphasis supplied; footnote omitted.)

This "governing principle" is precisely what petitioners have argued throughout this case, and it is the recognition of this principle which has eluded the district court below and the four members of the Eighth Circuit who affirmed that decision.

In addition, Judge MacKinnon, in a separate opinion, does not dissent from this aspect of the majority's analysis. His sole disagreement is with the majority's determination that deeming is not permissible between separated spouses in the 209(b) states. Id., at 1; CCH Medicare & Medicaid Guide, par. 30,588, at p. 10,419 (MacKinnon, J., concurring in part and dissenting in part). Indeed, he expressly acknowledges that the SSI states are bound by the SSI rules:

"States participating in the Medicaid program fall into two categories: those which determine eligibility under the Supplemental Security Income program ('SSI') Title XVI of the Social Security Act, 42 U.S.C. §1381, et seq.

(1976) and those states which have elected a more restrictive eligibility criteria. . . ." Id., at 2 n. 1; CCH Medicare & Medicaid Guide, par. 30,588, at p. 10,422 n. 1 (MacKinnon, J., concurring in part and dissenting in part).

There is no disagreement on the Gray Panthers panel as to the nature of the SSI states and the rules which Congress had required from them and which HHS has further detailed.

The Court of Appeals for the District of Columbia Circuit has carefully detailed the nature of the eligibility requirements which adhere in the SSI and 209(b) states. In so doing, it has repudiated the analysis of Judge Ross in the opinion below, and has recognized what has been apparent to all other courts which have considered the issue: that there is a necessary dependence of Medicaid eligibility conditions on SSI eligibility conditions. Without that relationship, there was no cause for Congress to provide the 209(b) option. But Congress did provide that choice, so that states which were dissatisfied with the SSI eligibility conditions would not be so restricted.

Iowa did not select that option, and consequently it should be locked into the SSI eligibility conditions. By permitting Iowa to go its own way, however, the Eighth Circuit has ignored explicit federal statutes, and the analyses of all other courts which have considered the issue. The opinion of the Court of Appeals for the District of Columbia Circuit adds significant support to that

prevailing analysis. This Court should therefore recognize the unwarranted deviation of the Eighth Circuit, and issue a writ to review that decision.

Respectfully submitted,

GILL DEFORD
NEAL S. DUDOVITZ
National Senior Citizens
Law Center

ROBERT L. BRAY
CARROLL LUCHT
Legal Services Corporation
of Iowa

Attorneys for Petitioners

Office - Supreme Court, U.S.
FILED
SEP 17 1981
ALEXANDER L. STEVAS
CLERK

No. 80-60

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1980

ELVINA M. HERWEG, by her husband and next friend, Darrell E. Herweg; and DARRELL E. HERWEG, on behalf of themselves and all others similarly situated,

Petitioners,

vs.

ROBERT D. RAY, individually and in his capacity as Governor of the State of Iowa; and KEVIN J. BURNS, individually and in his capacity as Commissioner of the Iowa Department of Social Services,

Respondents.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

JOINT APPENDIX

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RELEVANT DOCKET ENTRIES

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF IOWA

Civ. 77-222-1, Herweg v. Ray

Date	NR.	PROCEEDINGS
7-28-77	1	Complaint.
7-28-77	2	Pltfs' Motion for Temp. Rstrg. Order.
7-28-77	3	Pltfs' Motion for Class Action.
7-28-77	5	Acceptance of Service of summon, cplt. motion for TRO and motion for Class Action by Stephen C. Robinson, Special Asst. Atty. General State of Iowa.
7-28-77	6	Temporary Restraining Order; Pending further hearing & determination by this Court, defts. agents & employees and all other persons in active concert and participation with them are restrained from terminating

		Title XIX intermediate care medical assistance benefit payments. Stuart, J., Effective 11:45 am 7-28-77. (copies to attys.)
8-16-77	8	Pltf's Interrogatories to Defts.
8-17-77	9	Pltfs' Memorandum in Support of Certification as a Class Action.
9-15-77	11	Pltfs' Amended Complaint.
9-30-77	12	Defts' Response to Interrogatories. (Exhibits submitted with this pleading are in separate envelope in Court file folder.)
10-7-77	14	Stipulation as to undisputed facts.
10-2077	15	Pltfs' Memorandum in Support of their Request for Final Relief for Themselves and the Class Which They Represent.
10-21-77	16	Defs' Brief in Resis. to Preliminary Injunction.

10-25-77	17	Affidavit of Darrell E. Herweg, Ptnr.
11-3-77	20	Pltfs' Supplemental Memorandum Clarifying Citations in Original Memorandum.
11-15-77	21	Defts' Reply Brief (copy to Judge)
11-28-77	22	Pltf's Response.
		Memorandum Opinion and Order.
1-19-78	23	Pltfs' Request for class action certification granted. pltfs' request for final determination which Court elects to treat as motion for summary judgment granted; further ordered pltfs' request for permanent injct. against state deeming procedures is granted; further ordered that any other matters not disposed of in this opinion & Order will be considered upon application of party or parties; Pltfs. shall

prepare a Judgment Entry in accordance herewith, obtain defts. approval as to form & submit it to this Court for signature. Costs of this action are assessed against defts. Stuart, J. (59 OJ 44).

2--2-78 24 Judgment in Accordance with the Memorandum Opinion and Order of Jan. 19, 1978; Entered: Ordered and adjudged that pltfs' request for class action certification granted; further ordered and adjudged that pltfs' request for final determination has been treated by Court as motion for Summary Judgment and is granted; further ordered and adjudged that pltfs' request for permanent injunction against state "deeming" procedures granted; further

ordered and adjudged that any other matters not disposed of in the Opinion and Order will be considered on application of a party or parties; further ordered and adjudged that costs of this action are assessed against defts. as of costs accrued of this date. Rosenbaum, Clk. (copies to attys.) (59 OJ 93)

3-17-78	26	Pltfs' Motion for Relief Consistent with Court's Order of 1-19.
3-17-78	27	Pltfs' Memorandum in Support of Motion for Relief Consistent with Court's Order of 1-19.
3-22-78	28	Deft's Motion for Relief Consistent with Court's Order of 1-19-78;
3-22-78	29	Deft's Memorandum Brief in Support of Motion for Relief. (copy to Judge.)

3-31-78	30	Pltfs' Response to Defts' Concurrent Motion for Relief Consistent with Court's Previous Order.
4-27-78	32	Clerk's court Minutes Re: Oral hearing on motion for relief consistant with Court's Order; oral arguments by counsel. Matter submitted, Stuart, J.
5-10-78	33	Pltfs' Supplementary Brief in Support of their motion for Relief Consistent with Court's Previous Order. (copy to Judge).
6-27-78	34	Defts' Reply Brief (copy to Judge)
7-10-78	35	Order; Ordered proposed manual letter submitted by defts. at hrg. is specifically approved except it must specifically point out Soc. Sec. benefits, Railroad Retirement Board annuities and Civ. Serv. Com. annuities are to be

disregard; further ordered that Order of Court dated 1-19-78 is declared to be retroactive to 7-28-77; further ordered parties have 10 days fr. date of Order to submit objections if any to class notice attached to this Order. If no objections filed, notice shall be sent to all members of class as expeditiously as possible. Stuart, J. (copies to attys.)

8-4-78	37	Final Order; Ordered and adjudged that pltfs. have summary judgment in accordance with previous orders and judgment and further ordered that Class Notice attached as Ex. A to Ruling & Order of 7-10-78 shall be sent to all members of class as expeditiously as possible. Court will retain jurisdiction of case for an indefinite period to

		ensure that there is compliance with these rulings. Stuart, J. (copies to attys.) (61 OJ 151)
8-4-78	38	Judgment: Ordered Class action certification granted, Pltfs. motion for summary judgment granted; pltfs' request for permanent Inct. against state "deeming" procedures granted; Class notice to be mailed to members of class as soon as possible. Rosenbaum, Clk. (copies to attys.) (61 OJ 152)
8-7-78	39	Pltfs' Motion for Award of Attys' Fees.
8-7-78	40	Pltfs' Memorandum of Points & Authorities in support of Pltfs' Motion for Attys' Fees.
8-7-78	41	Pltfs' Affidavit of Gill DeFord. (re: motion for atty. fees)

8-8-78	42	Notice of Appeal by pltfs.
8-10-78	43	Certificate of Service of Notice of Appeal by pltfs.
8-15-78	44	Affidavit of Robert L. Bray. (re: Motion for Attorneys Fees)
8-17-78	45	Defs' Combined Motion for Continuance and Response to Motion for Award of Atty's Fees.
9-11-78	46	Pltfs' Reply to Defts' Opposition to Pltfs' Motion for Atty's Fees.
10-27-78	47	Order; Pltfs' Mtn. for atty's fees denied for lack of jurisdiction of subject matter. Stuart, J. (copies to attys.)
5--5-80	48	Attsd. copy of OPINION fr. 8th CCA.
5-5-80	49	Attsd. copy of JUDGMENT MANDATE fr. 8th CCA; Ordered and adjudged judgment of district court affirmed except that portion relating to the sources of income

		the state may consider as available to Medicaid applicants and recipients which is reversed and remanded. /s/ A true Copy, Robert D. St. Vrain, Clk. 8th CCA; copies to attys. c. to Judge.
1-30-81	50	ORDER: Parties directed to report to Court in 10 days as to Status of this action & why it should not be closed. Stuart, J. (copies to attys.)
2-6-81	51	STATUS REPORT by Pltfs.
2-9-81	52	Status Report by Defts.
5-7-81	53	First Updated Status Report.

GENERAL DOCKET

UNITED STATES COURT OF APPEALS
FOR THE
EIGHTH CIRCUIT

Case No. 78-1664

DATE 1978	Filings-Proceedings	Filed
Aug. 21	Cert. copies Notice of Appeal, Docket Entries of D. Ct. (1)	
" "	Request for docketing fee. (2)	
Sept 14	Docketed case	
" "	Appearance for appellants (3)	
"	Appearance for appellee (4)	
"	Appearance for appellee (5)	
Oct 19	Appendix 0+5 w/ser (6)	
" "	Brief Appellant w/ser. 10 copies (7)	
Nov 15	Brief Appellee w/ser. 10 copies (8)	
Nov 29	Reply Brief w/ser 10 copies (9)	
DEC 18 1978	Transferred to January session.	
Dec 18	Received letter from counsel for appellant with attachment. To Court.	

1979

Jan 12 Argued and submitted to Judge Ross, McMillian, Van Sickle. Gill Deford for appellant; Stephen Robinson, Asst. Atty Gen. for appellee. Rebuttal by Mr. Deford. Recorded

May 4 Motion appellant for lv to file supplementary brief. (10)

May 4 Received supplementary brief appellant.

May 7 ORDER: Motion of appellants for leave to file supplementary brief is granted; supplemental brief is filed; appellees may have ten days from date of this order to file an appropriate response (11)

May 7 Supplementary Brief Appellants 0/4 (w/service) (12)

May 21 Supp. brief Appellee w/ser. 10 copies (13)

June 27 Mo appellants for lv to file second supplementary brief. (14)

June 27	Received appellants second supplementary brief.
July 3	ORDER: Appellants' motion to file second supplementary brief is denied. (15)
Aug. 10	ORDER: Present submission of appeal to a panel of Judges on 1/12/79 is vacated & set aside. Court concludes to re-submit this case to Court en banc. Clerk of this Court directed to calendar case for oral argument and submission to Court en banc on Monday, September 10, 1979. (16)
Aug 10 1979	Transferred to September session.
Aug 20	Mo appellants for order setting Aug. 31, 1979, as date for filing HEW amicus brief. (17)
Aug. 23	ORDER: Motion of appellants for an order setting 8/31/79 as date on or before which Dept. of HEW may submit a brief amicus curiae is granted;

	therefore, brief amicus curiae of the Department of Health Education & Welfare is due to be served and filed on or before 8/31/79 (18)
Sept. 4	Received letter from counsel for appellants with attachment (order of dist. ct. in Utah) -- to court en banc.
Sep 10	Brief Amicus Curiae w/ser. 15 copies (19)
Sept 10	Argued and submitted to the Court En Banc; Judges Gibson, Lay, Heaney, Bright, Ross, Stephenson, Henley, McMillian. Gill Deford for appellants; Stephen C. Robinson, Asst. Atty Gen. for appellee. Rebuttal by Mr. Deford. Recorded
Sep 20	Brief in Response to Amicus w/ser. 11 copies (20)
Sep 26	ORIGINAL FILE OF DISTRICT COURT (2 vol) and Env. EXHIBITS

Oct. 10	Letter from Asst. Attorney General in resp. to request at oral arg.
Nov. 28	Motion appellants for leave to file supplemental brief. (21)
Dec. 4	ORDER: Appellants' motion for leave to file supplemental brief is granted. Clerk directed to file tendered supplemental brief. (22)
Dec. 4	Appellants' Supplemental Brief. (23)
1980 Jan. 14	Letter (Deford) and Mo. Ct. Appeals opinion --fwd to ct.
Feb. 6	Received from appellant opinions in Norman v. St. Clair and Brown v. Stanton, forwarded to Court en banc.
Mar. 18	OPINION by Judge Ross, Concurred in by Gibson, Bright & Henley. and OPINION by Judge McMillian, Concurred in by Lay, Heaney & Stephenson. (Published) (24)

Mar. 18	JUDGMENT: Judgment of District Court is affirmed except that portion relating to the sources of income the State may consider as available to Medicaid applicants and recipients which is reversed and remanded. (25)
Mar. 31	PETITION of appellants for rehearing. (w/service) (26) (NOTE: SENT TO COURT EN BANC BECAUSE SUBMISSION OF 9/10/79 WAS EN BANC AS WAS OPINION OF 3/18/80)
Apr. 18	MOTION of appellants for recusal. (27)
Apr. 18	ORDER DENYING MOTION TO RECUSE: Motion is denied. (Unpublished) (28)
Apr. 22	RECEIVED letter from counsel for appellants, with attachments. -- to court en banc.
Apr. 22	ORDER: Petition for rehearing is denied. (Unpublished) (29)

May 2 MANDATE issued.

May 7 RECEIPT for mandate. (30)

July 17 NOTICE OF filing petition for writ of certiorari in the Supreme Court of the United States as Case No. 80-60 (as of 7/10/80). (31)

1981

July 6 ORDER of Supreme Court granting certiorari in #80-60, dated 7-2-81 (32)

IN THE UNITED STATES DISTRICT COURT

FOR THE SOUTHERN DISTRICT OF IOWA

ELVINA M. HERWEG, by her husband and next friend, Darrell E. Herweg; and DARRELL E. HERWEG, on behalf of themselves and all others similarly situated, Plaintiffs, vs. ROBERT D. RAY, individually and in his capacity as Governor of the State of Iowa and KEVIN J. BURNS, individually and in his capacity as Commissioner of the Iowa Department of Social Services, Defendants.	NO. 77-222-1 AMENDED COMPLAINT

1. This is a class action for declaratory and injunctive relief pursuant to 42 U.S.C. §1983, 28 U.S.C. §2201 and §2202 which arises under the Constitution and the laws of the United States. Plaintiffs, individually and on behalf of all other persons similarly situated, seek to have this court declare invalid and enjoin the enforcement of Iowa

Department of Social Services (hereinafter, the "Department") policies and practices found in Social Services Manual (hereinafter, the "Manual"), Letter No. X11-1-28 (Part Two) dated June 3, 1977 (attached hereto as Exhibit "A") and authorized by House File 464 §18 Acts of the 67th General Assembly (attached hereto as Exhibit "B") through which a portion of the income of a noninstitutionalized spouse is deemed available to meet the needs of an institutionalized spouse who receives Medicaid benefits without regard to whether the noninstitutionalized spouse is capable of providing the deemed amount to the institutionalized spouse, or whether the deemed amount is actually available to the institutionalized spouse. The statute, regulations, policies and practices are challenged on the grounds that they are in conflict with the Supremacy Clause of the United States Constitution, the Fourteenth Amendment to the United States Constitution, the Social Security Act, 42 U.S.C. §1396 et. seq.,

federal regulations promulgated thereunder and 42 U.S.C. §1983.

JURISDICTION

2. Jurisdiction is conferred upon this court by 28 U.S.C. §1343(3) and §1343(4) which provide for the original jurisdiction of this court over all suits authorized by 42 U.S.C. §1983 to redress the deprivation under color of state law of any right, privilege or immunity secured by the Constitution of the United States or by an Act of Congress providing for equal rights or civil rights of all persons within the jurisdiction of the United States. Substantial questions of Federal Constitutional and statutory law are involved. Jurisdiction is also conferred by 28 U.S.C. §1331; more than $10,000 is at stake in this controversy.

3. Plaintiffs' action for declaratory and injunctive relief is authorized by 42 U.S.C. §1983, and by 28 U.S.C. §§2201, 2202 and Federal Rule of Civil Procedure 57.

PARTIES

4. Plaintiff Elvina M. Herweg is an adult resident of Iowa who is totally and permamently disabled and currently in a comatose condition. She brings this action by her husband and next friend Darrell E. Herweg. Plaintiff Darrell E. Herweg is a resident of Council Bluffs, Iowa.

5. Defendant Robert D. Ray is sued individually and in his official capacity as Governor of the State of Iowa. In his official capacity the defendant is the chief executive officer of the state and is charged to see that the laws of the state are executed.

6. Defedant Kevin J. Burns is sued individually and in his official capacity as Commissioner of the Iowa Department of Social Services. In his official capacity the defendant is the chief executive officer of the Department and is vested with general supervisory power and

control of Department personnel and policies concerning the operation of Title XIX of the Social Security Act, the Medical Assistance Program.

CLASS ACTION

7. Plaintiffs bring this action on their own behalf and pursuant to Rule 23(a) and (b)(2), Federal Rules of Civil Procedure, on behalf of all others similarly situated. The class which the plaintiffs represent consists of all married couples residing in Iowa of which: (a) one spouse is eligible for Medicaid and requires institutionalization; (b) the other spouse is not institutionalized; and (c) the noninstitutionalized spouse has income which is deemed available to the institutionalized spouse. The class is so numerous that joinder of all members is impracticable. There are common questions of law and fact. Plaintiffs' claims are typical of the claims of all class members, and plaintiffs will fairly and adequately protect the interests of

the class. Defendants have acted and continue to act on grounds generally applicable to all class members, thereby making declaratory and injunctive relief appropriate with respect to the class as a whole.

STATUTORY AND REGULATORY FRAMEWORK

8. The Medical Assistance Program (commonly known as "Medicaid"), is a cooperative federal-state program established pursuant to Title XIX of the Social Security Act, 42 U.S.C. §1396 et. seq. In accordance with the Act, the Secretary of Health, Education and Welfare promulgates regulations, 45 C.F.R. §248 et. seq., which, in addition to the statutes, provide the framework in which the states must develop and operate their Medicaid programs.

9. Iowa has chosen to participate in the Medicaid program, and as an element of that participation, Iowa provides Medicaid to individuals

meeting the eligibility conditions, which include an income of no more than $503 per month.

10. For those married individuals who apply for Medicaid assistance to help defray the cost of institutionalized care, Iowa employs a complicated computation to determine what portion of the income of a noninstitutionalized spouse will be considered available to the institutionalized spouse. This calculation is made without regard to the actual needs of the noninstitutionalized spouse or other members of the family, but is instead reached using an arbitrary formula.

11. By employing this arbitrary methodology, defendants place noninstitutionalized spouses in a difficult position of either paying the deemed amount, a financial burden which is often impossible to bear, or of not paying the required amount with the eventual result that the institutionalized spouse will be evicted from the nursing home.

12. The defendants caused to be filed with the Department of Health, Education and Welfare a state plan for the conduct of the Title XIX Medical Assistance Program which failed to comply with federal standards as set forth at 45 C.F.R. §248.3(b), 42 Fed. Reg. 2686 (January 13, 1977). When the regional commissioner of the Social and Rehabilitation Service of the Department of Health, Education and Welfare asked for amendments to the State Plan, defendant Kevin Burns replied by letter dated June 15, 1977 that the state would not amend the plan in compliance with the regulations. (A copy of that letter is attached hereto as Exhibit "C.")

STATEMENT OF CLAIM

13. Plaintiff Elvina M. Herweg was born on December 21, 1930 and is now forty-six years old. Elvina and Darrell Herweg were married July 30, 1949.

14. In August, 1976, Elvina collapsed in the front yard of her home and was rushed to Mercy hospital by a young neighbor. At Mercy, it was discovered that she had suffered an aneurism and cerebral hemorrhage on the left side. An operation was performed to repair the damage to the left side. Within twenty-four hours, plaintiff suffered another aneurism and hemorrhage on the right side which was also surgically treated. Plaintiff has been in a comatose state since she first became unconscious.

15. Plaintiff Darrell Herweg was instructed by the hospital social worker to apply for medical assistance for his wife's hospital care on October 7, 1976, and assistance was granted. Plaintiff Elvina Herweg was determined to be permanently and totally disabled.

16. On January 20, 1977, Mr. Herweg applied for assistance for an extended care facility. The plaintiff, Elvina Herweg, had been placed on

November 1, 1976, in a skilled long-term facility, the Americana Home in Des Moines.

17. Mr. Herweg has contributed to his wife's care while she has been in the nursing facility. Mr. Herweg currently is employed as a butcher in Hinky-Dinky stores and has a gross income of $1,350.00 a month, with a net of $1032.00. Mr. Herweg presently has three teenage daughters living at home.

18. Based on Department computation, Mr. Herweg contributed $234.80 to the nursing home for his wife's care in April, May and June. Mr. Herweg's current expenses exceed his monthly income.

19. The cost of Mrs. Herweg's care is approximately $1,374.00 per month, excluding drug and doctor bills.

20. On June 2, 1977, the Department issued a Notice of Decision (attached hereto as Exhibit "D") cancelling medical assistance for Elvina Herweg effective June 30, 1977, because

Mr. Herweg's income was deemed available to Elvina Herweg.

21. On June 7, 1977, plaintiff Darrell Herweg appealed the decision to cancel assistance (attached hereto as Exhibit "E").

22. On July 15, 1977, the Department held a hearing for the prupose of considering the appeal.

23. On July 21, 1977, the Department issued a decision (attached hereto as Exhibit "F") affirming the earlier decision.

24. On August 11, 1977, a new "Proposed Decision" was issued in which a different computation formula was used. (A copy of that decision is attached hereto as Exhibit "G.") Although that decision permits eligibility for Medicaid, an arbitrary portion of the income of plaintiff Darrell Herweg is still deemed available to plaintiff Elvina Herweg.

25. There is harm to plaintiff Elvina Herweg in that she will be unable to continue to receive necessary nursing home care if her husband is unable to pay the deemed amount. Her husband is similarly injured by the requirement that he pay an arbitrary portion of his income to the nursing home.

26. The harm which plaintiffs are suffering and will continue to suffer if defendants are not restrained from their illegal and unconstitutional acts are not susceptible of redress by a mere award of money damages. Only immediate injunctive relief can insure the continuation of needed medical services to plaintiff Elvina Herweg, and the ability of plaintiff, Darrell Herweg, to meet the basis living expenses for himself and his three children.

FIRST CLAIM FOR RELIEF

27. The "deeming" practices and procedures employed by defendants pursuant to the

Manual and House File 464 §18, 67th General Assembly, violate the applicable implementing regulations, 45 C.F.R. §248.3(b), which require that the state not deem income available from a noninstitutionalized spouse to an institutionalized spouse after the end of the calendar month in which the institutionalized spouse first enters the institution.

SECOND CLAIM FOR RELIEF

28. The "deeming" practices and procedures employed by defendants pursuant to the Manual and House File 464 §18, 67th General Assembly, violate the Medicaid statute, 42 U.S.C. §1396a(a)(17), which requires that: (1) the state have reasonable standards for determining eligibility for Medicaid assistance; (2) that it provide that only income and resources actually available to the recipient of Medicaid benefits be considered; (3) that income and resources be reasonably evaluated; and (4) the state take into account, for

the purposes of determining an appropriate payment from the noninstitutionalized spouse, the income and resources of only those relatives who are legally responsible.

THIRD CLAIM FOR RELIEF

29. The practices and procedures of defendants create an irrebuttable presumption that the noninstitutionalized spouse is capable of paying the amount computed by the formula set forth in the Manual and that the deemed amount is actually available for the care of the institutionalized spouse. These irrebuttable presumptions, which are not rationally related to a legitimate state interest, violate the Due Process Clause of the Fourteenth Amendment to the United States Constitution.

FOURTH CLAIM FOR RELIEF

30. By imposing an additional eligibility condition on otherwise eligible Medicaid recipients,

defendants create two classes of Medicaid recipients. One consists of unmarried institutionalized Medicaid recipients, and the other consists of married institutionalized Medicaid recipients. The discriminatory treatment of the class of married institutionalized Medicaid recipients, whose continued receipt of necessary health care is dependent upon the payment of an arbitrary amount by their noninstitutionalized spouse, is irrational and capricious and therefore violates the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution.

REQUEST FOR RELIEF

Wherefore, plaintiffs respectfully request on behalf of themselves, and all other persons similarly situated, that this Court:

1. Assume jurisdiction over this case.

2. Determine by order, pursuant to Rule 23(c)(1), that this action be maintained as a Rule 23(b)(2) class action.

3. Enter preliminary and permanent injunctions pursuant to Rule 65 of the Federal Rules of Civil Procedure enjoining defendants, their successors in office, agents and employees and a all other persons in active concert and participation with them, from enforcing the state practices and procedures which require that an arbitrary portion of the income of a noninstitutionalized spouse of an institutionalized recipient of Medicaid is deemed available for the care of the institutionalized spouse without regard to the actual living costs of the noninstitutionalized spouse.

4. Declare that defendants' enforcement of the "deeming" formula violates the applicable implementing regulations of the Medicaid statute, 45 C.F.R. §248.3(b).

5. Declare that defendants' enforcement of the "deeming" formula violates the applicable portion of the Medicaid statute, 42 U.S.C.

§1396a(a)(17).

6. Declare that defendants' enforcement of the "deeming" formula amounts to an irrebuttable presumption in violation of the Due Process Clause of the Fourteenth Amendment to the United States Constitution.

7. Declare that defendants' enforcement of the "deeming" formula creates an arbitrary classification in violation of the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution.

8. Award plaintiffs their costs incurred herein, including reasonable attorneys' fees.

9. Grant such other and further relief as to the court seems just and proper.

Respectfully submitted,

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By /s/
Robert L. Bray

Attorneys for Plaintiffs

EXHIBIT A

STATE OF IOWA
Department of Social Services
Des Moines

June 3, 1977

SOCIAL SERVICES MANUAL LETTER
NO. XII-1-28 (Part Two)

SUBJECT: TITLE XIX MEDICAL ASSISTANCE - Title XIX Medical Institution: Eligibility Standard, Social Security Increase and Revision of Client Participation

1. Title XIX Medical Assistance - Financial Eligibility

A. Financial Eligibility Standard

After the July 1976 Social Security/Supplemental Security Income Increase the Department's Administrative Rules were changed in regard to the income limitation for eligibility in a Title XIX medical institution. The Title XIX medical institution income limitation for eligibility was frozen at $503 per month or the cost of care in the facility whichever is the lesser amount. This income limitation will remain at

$503 whether or not there is an increase in the SSI payment amount. The SSI cost of living increase effective 7-1-77 is the first time the frozen figure has affected eligibility.

B. Correction in Eligibility Income Computation

We have been advised by the Department of Health, Education and Welfare that the method we are currently following in computing monthly income for purposes of comparison with the $503 income limitation is wrong. The incorrect policy is outlined in Employees' Manual, XII-1-12 (Part Two), Determination of Income for Eligibility Purposes and Social Services Manual Letter XII-4-7 dated October 15, 1974.

To correctly compute Title XIX medical institution financial eligibility the $25 personal allowance shall not be disregarded or excluded prior to comparing the gross income figures or cost of care figure of

the individual for eligibility purposes. The amount of the July 1977 Social Security cost of living increase is not to be disregarded in determining income for eligibility purposes on institutional cases. (Further instructions pertaining to this disregard in non-institutiional cases will be issued shortly.)

In determination of monthly income for purposes of comparison with the $503 or cost of care limitation in the case of an individual without dependents outside the institution, total monthly income exclusive of any disregards is to be compared with the limitation. If there is a spouse and/or dependent children living in a home outside the institution certain exclusions are applicable. An exclusion of $177.80 (after a disregard of $20.00 of earned or unearned income) for the spouse plus $88.90 per dependent child in the home will apply.

In addition, if the ineligible spouse and/or dependent children have established medical needs the monthly amount of this medical need may be excluded. If the spouse and/or dependents have earned income an exclusion of $65.00 per month is applicable. These exclusions are applied to total family income and any balance remaining is considered available for purposes of comparison with the financial eligibility limitation of $503.00.

Note that these amounts will be applicable on and after July 1, 1977. The old amounts set forth in Employees' Manual, XII-1-12 (Part Two) should be utilized in computing income for eligibility purposes for any retroactive period before July 1, 1977 in the case of applications currently being processed. Note also that subsequent to July 1, 1977, the earned income exclusion will be limited to $65 per month. One-half of the balance

of earned income will no longer be excluded subsequent to that date. This is also applicable to computation of client participation (See Section III).

C. Procedures For Correction of Title XIX Medical Institution Eligibility on Active Cases

Prior to July 1, 1977, the local office shall:

1. Review all cases in medical institutions having income and recompute gross monthly income according to the above instructions.
2. Compute the Social Security cost of living increase as instructed later in this letter.
3. Any case with gross income in excess of $503 shall be terminated in accordance with the timely and adequate notice procedure, i.e., prepare and issue the Notice of Decision, PA-3102-0.
4. Prepare Form 278LM. The termination must be in the case data system prior to

4:30 p.m., June 24, 1977 for the cancellation to be effective July 1, 1977.

D. New Approvals Effective July 1, 1977

All new approvals processed during June 1977, shall be based on the above eligibility guidelines. Eligibility for July 1977 Title XIX payments shall be determined on the increased Social Security benefit as per computation instructions below. The income eligibility for three months eligibility prior to July 1 shall be based on the old Social Security rate and old exclusions.

EXHIBIT B

HOUSE FILE 464

AN ACT

RELATING TO THE ADMINISTRATION AND FINANCING OF CURRENT PROGRAMS UNDER THE JURISDICTION OF THE DEPARTMENT OF SOCIAL SERVICES AND TO FUNDING OF CAPITAL IMPROVEMENT PROJECTS INCLUDING CAPITAL IMPROVEMENT PROJECTS RECOMMENDED BY THE ADVISORY COMMISSION ON CORRECTIONS RELIEF.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. There is appropriated from the general fund of the state for the fiscal year beginning July 1, 1977 and ending June 30, 1978 to the department of social services, the following amounts, or so much thereof as may be necessary, to be used for the purposes designated:

1977-1978

Fiscal Year

1. District Administration

For the administration of district and local offices including salaries and support ..... $ 10,250,000

The provisions of subsection nine (9) of section nineteen A point nine (19A.9) of the Code which restricts employment of intermittent employees to not more than a specified number of calendar days in any twelve-month period without examination, shall not apply during the period beginning on July 1, 1977 and ending June 30, 1978 for forth intermittent employees who are employed in field offices by the department of social services. It is the intent of the general assembly to authorize the continued employment during the 1977-1978 fiscal year of persons employed to assist in meeting the current high demand for income maintenance and related services and to permit the department to avoid the cost of training new employees. Any such employee

of the department of social services who has been employed and classified as an intermittent employee after August 1, 1975 for twelve consecutive months or more shall be eligible to receive the same fringe benefits for fiscal year 1977-1978 as any other person employed under the provisions of chapter nineteen A (19A) of the Code.

2. State Administration

a. For salaries, support, maintenance and miscellaneous purposes ..... $ 4,389,000

Included in this appropriation for state administration is twenty-five thousand (25,000) dollars for one additional prosecutor for the fraud unit.

3. Medicaid Management Information System (MMIS)

For development and implementation of medicaid management information system.....$ 140,000

Sec. 2. There is appropriated from the general fund of the state for the fiscal year beginning July 1, 1977 and ending June 30, 1978 to the department of social services, the following amounts, or so

much thereof as may be necessary, to be used for the purposes designated:

1977-1978

Fiscal Year

FAMILY AND CHILDREN SERVICES:

For the operation of the following institutions:

1. State juvenile home at Toledo ..... $ 1,275,000
2. Boys' training school at Eldora ..... $ 3,100,000
3. Girls' training school at Mitchellville..... $ 1,000,000
4. Iowa veteran's home at Marshalltown..... $ 7,520,000
5. Juvenile community based

3. It is the intent of the general assembly to fully fund the addition to the aid of families with dependent children program as it applies to dependent children through the age of twenty years. If funds appropriated by this Act are insufficient to carry out this intent, it is the intent of the general assembly that a supplemental appropriation will be made by the general assembly meeting in the year 1978 to fund the program as intended.

Sec. 14. The department of social services shall incourage voluntary participation of families in paying for a portion of the care delivered to a relative/resident in an intermediate care facility. Facility administrators and appropriate department personnel, both state and county, will be advised as to the proper method of implementing family participation.

Sec. 15. It is the intent that the department of social services shall increase the maximum reimbursement for intermediate care facility

services under medicaid from nineteen dollars to nineteen dollars and fifty cents and that the department shall increase the fee paid to pharmacists under medicaid from two dollars and fifteen cents to two dollars and fifty-five cents.

Sec. 16. It is the intent of the general assembly that the department of social services, by July 1, 1977, shall review every state staffing requirement contained in the conditions of participation for intermediate care facilities participating in the medicaid program that exceeds federal government requirements and that any such conditions of participation be submitted to the administrative rules review committee.

Sec. 17. The department of health shall delay implementation of the department of health licensure rules for intermediate care facilities as published in the Iowa Administrative Code "Health (470) chapter 58". The department, upon consultation with the health facilities advisory committee, shall review these rules which exceed the federal

Title XIX guidelines for intermediate care facilities. All such modified rules approved by the department of health shall be resubmitted to the administrative rules review committee. The department of health may promulgate rules in areas not addressed by federal regulations.

Sec. 18. It is the intent that the department of social services shall resist the implementation of the federal government spouse income regulation which would allow spouse income under certain circumstances to be excluded from the determination of income for intermediate care facility medicaid eligibility purposes.

Sec. 19. It is the intent of the general assembly that funds appropriated for medical assistance shall not be used to pay for radiology services provided by a computerized axial tomographic scanner placed in operation in the state of Iowa subsequent to the effective date of this Act unless said computerized axial tomographic scanner has been approved by

the health facilities construction review committee of the state department of health.

Sec. 20. Section two hundred twenty-two point eighty-six (222.86), Code 1977, is amended to read as follows:

222.26 PAYMENT FOR CARE FROM FUND. Whenever the amount in the account of any patient in the patients' personal deposit fund exceeds the sum of two hundred dollars, the business manager of the hospital-school or special unit may apply any amount of the excess to reimburse the county of legal settlement for liability incurred by such county for the payment of care, support, and maintenance of the patient when billed therefor by the county of legal settlement. Money-earned-by-a-patient-for-work-performed-in-or-by-a-hospital-school-or-special-unit-shall-not-be-subject-to-this-section-or-to-attachment.

Sec. 21.

1. The department of social services shall implement a pilot program in community services

EXHIBIT C

STATE OF IOWA

DEPARTMENT OF SOCIAL SERVICES

Lucas State Office Building
Des Moines, Iowa 50319

Robert D. Ray
Governor
Kevin J. Burns
Commissioner

June 15, 1977

Mr. Robert Davis
Regional Commissioner
Social and Rehabilitation Services
Medical Services Administration
Dept. of Health, Education and Welfare
601 East 12th Street, Room 564
Kansas City, Missouri 64106

Dear Mr. Davis:

The purpose of this letter is to inform you that the State of Iowa does not anticipate the submittal of amendments to the state plan pursuant to Action Transcmittals SRA-AT-77-4 and 77-6 as specifically related to Federal Regulations 45 CFR 248.3 and 248.21.

We have determined that the revised regulations, which require that the rules for considering income

and resources of a spouse or parent available to an applicant or recipient of Medicaid assistance will be the same as those applied under SSI, are not in the best interest of the state or its citizens. More specifically:

- The General Assembly of the State of Iowa has formally expressed its intent that the state not implement the subject regulations with respect to the deeming of spouses income.
- Conformance to the regulations will serve to increase expenditures and not necessarily result in improved or expanded care for those individuals receiving services under the Medicaid program who can be classified as the most needy.
- The regulation further compounds the complexity of an eligibility process which is already burdensome and once again unilaterally passes costs on to the state without adequately assessing the impact of such action upon individual state programs.

- The proposed regulation did not contain the inflationary impact statement required by OMB Circular A-107. We estimate the change requirements will cost an additional $5,300,000 per year. Given our current budget limits this is an amount which cannot readily be assured without adverse program effects.
- The state has not been able to develop an effective and equitable method of redetermining eligibility for individuals receiving Medicaid services where currently a spouse's income is being deemed while maintaining our present quality of eligibility determination.
- The regulation is in conflict with Chapter 252, Iowa Code and in our view exceeds the authority provided by the Social Security Act for such regulatory action.
- If the Department of Health, Education and Welfare prevails in the imposition of this regulation, the state may have to revise the state plan and revert to a program which does

not accept all SSI eligibles for Medicaid Services thereby reducing the number of persons eligible for medical assistance and in turn prompt the termination of our contract with the Social Security Administration for determining eligibility for SSI recipients of medical services, actions we do not voluntarily wish to take.

In closing, it is paradoxical that HEW would choose to inflate, by regulatory action, the cost and complexity of medical programs at a time the president is calling for welfare reform and limitations on hospital charges.

The state is committed to provide assistance to its needy citizens consistant with utilizing all resources available. To this end, we pledge our continued cooperation.

Very truly yours,

/s/

Kevin J. Burns
Commissioner

KJB/PB/ff

cc: Susan Michelson - Governor's Office

Lee Galeotos - Comptroller's Office

George Cosson - Legal

C. Joseph Baker

Harold Templemon

Catherine Williams

Appeals

XIX SRS Correspondence

PB

CB

EXHIBIT D

STATE OF IOWA

Department of Social Services

Des Moines

NOTICE OF DECISION

Medical Assistance or State Supplementary Assistance

Elvina Herweg

327 9th Ave.

Council Bluffs, Iowa
31501

[Because of the poor quality of copying, and hand-writing which is difficult to decipher, it is impossible to reprint this page. Under the section listed "Action Taken," however, the box is checked which reads: "Your assistance has been cancelled effective 6-30-77."]

EXHIBIT E

State of Iowa

Department of Social Services

NOTICE OF APPEAL

Name of Appellant. Elvina Herwig by husband Darrell Herwig

Address. American Nursing Home Des Moines,
Street or R.F.D. Town

Iowa 50300 Polk C.
or City Zip Code County

Program. Skilled Nursing #81 Case No. 372068

To the Council of Social Services:

My complaint is that "See attached memo"

Therefore, I respectfully make application for a review by the Council of Social Services of the State of Iowa for a redress of the grievance herein stated, as provided by Section 241.11, (AB), Section 249.11, (OAA), Section 239.7, (ADC), Section 241A.8, (AD), Code of Iowa; Chapter 223,

Section 5 of the Acts of the 62nd G.A. (MA).

6-7-77
..... (Date)

..... (Signature of Appellant or Guardian*)

Note: If due to incapacity the appellant is unable to enter his signature, the signature of the person acting for him shall be entered on this line. However, if the appellant has filed his appeal orally or by submitting a signed letter, no signature be entered.

PA 31380 (Revised March 4, 1969)

cc: 4

State of Iowa

Department of Social Services

INTEROFFICE MEMORANDUM

Pottawattamie County
Department of Social Services
231 Pearl Street
Council Bluffs, Iowa 51501

June 7, 1977

To: Appeals Office
Department of Social Services

From: Jeanne Hatfield, IMW-I (JH)
Pottawattamie County Department of Social Services

Subject: Oral appeal of Elvina Herwig requested by husband Darrell Herwig
Cancellation of Title XIX

Mr. Herwig contacted me 6-6-77 to discuss attached Notice of Decision received from Becky Atess IMW-I, Polk County. Notice of Decision stated that Elvina's Title XIX would be cancelled effective 6-30-77 due to manual letter XII-1-28 (part two) new State Policy, Client Participation.

Mr. Herweg orally appealed this eligibility determination by Polk County. He stated, "I am

unable to pay for my wifes care in the Nursing Home." He further stated that considering his gross income rather than his net income was unfair.

Mr. Herwig request that this hearing be held in Pottawattamie County rather than in Polk County.

JH/lp

Enclosures

(ND-6/2 - cancelled eff 6/30 - over income appealed 6/6 -

Polk -C (Becky Atess) - will leave same;

784-6544 Notify her of hearing)

RECEIVED
JUN 10 1977

Appeals and Fair Hearing

EXHIBIT F

State of Iowa

Department of Social Services

Des Moines

NOTICE OF DECISION

Medical Assistance or State Supplementary Assistance

Elvina Herweg
327 9th Ave.
Council Bluffs,
Iowa 51501

County Polk Date 7-21-77

Case No. 372068-00-0

Program ECF

Action: ☐ Approval ☐ Review
☐ Denial ☐ Redetermination
☐ Transfer ☒ Cancellation

Name of Facility Americana

Action Taken

1. ☐ Your application has been approved effective _____. Medical benefits are effective _____. Your personal allowance is $_____ and you are requied to contribut $_____ per month toward the cost of your care, beginning _____.

2. ☐ Your application has been denied.

3. ☐ As a result of your transfer from one facility to another you will be required to pay $_____ for the first month and $_____ per month thereafter.

4. ☐ A review of your circumstances indicates that you continue to be eligible for assistance.

5. ☐ Your assistance has been cancelled effective _____.

6. ☐ You have been approved for Medical Assistance effective _____.

7. ☒ Your Medical Assitance has been cancelled effective 7-21-77.

Comments by Worker: Appeals officer stated that this was a matter of policy and upheld the previous cancellation.

Payment Computation

Income From:	Amount
_____	$_____
_____	_____
_____	_____
_____	_____
Total.....	_____

less:

Diversion of Income for Spouse

and/or Dependent

_____	$_____
_____	_____
_____	_____
_____	_____
Personal Allowance.....	_____
Total.....	_____

Total Income $_____
Less Diversions_____

Client
Participation$_____

If you do not agree with the above decision, you may discuss the decision and your situation with the agency staff, obtain an explanation of the action and present information to show that the action is incorrect. You may speak for yourself or be represented by legal counsel or by a friend or other spokesman.

This conference does not in any way diminish your right to a fair hearing described on the back of this page. If your application has been rejected

or your assistance has been cancelled, you have the right to re-apply at any time.

PA 3159-0 (1/77)

Becky Atess 284-6544
Income Maintenance
Worker/Phone Number

RIGHT OF APPEAL

If you are dissatisfied with any action or failure to act with regard to your application for public assistance or medical assistance; with regard to the assistance you are now receiving, or because such assistance has been cancelled, you have the right to appeal. (A hearing need not be granted, however, when either state or federal law requires automatic grant adjustments.) You may appeal in writing or orally to the local office of the Department of Social Services, or directly to the Department of Social Services, Robert Lucas State Office Building, Des Moines, Iowa 50319.

You may present your appeal at the hearing yourself or have someone else present it for you. If you wish, you may be represented at the hearing by

an attorney. However, there are no provisions whereby the Department can pay the attorney's fee.

If you request an appeal because of a reduction or termination of your grant within ten calendar days from this notice, assistance will be continued at the present level at least until the time of the hearing. However, such assistance may be subject to recovery if the action is sustained.

The Civil Rights Act of 1964 prohibits any discrimination on the ground of race, color, or national origin in the administration of the public welfare programs. The Act also prohibits discrimination by vendors supplying goods and/or services to recipients for which payment is made directly or indirectly from public assistance funds. Any person who feels he may have been the object of such discrimination may file a complaint with the local office of the Department of Social Services, the State Department of Social Services, or the Federal Department of Health, Education and Welfare.

EXHIBIT G

STATE OF IOWA

DEPARTMENT OF SOCIAL SERVICES

Lucas State Office Building Des Moines, Iowa 50319

Robert D. Ray
Governor

Kevin J. Burns
Commissioner

August 11, 1977

Darrell Herwig for Elvina Herwig
Appeal #81
Polk County

PROPOSED DECISION

This is a PROPOSED DECISION. it will be come a FINAL DECISION in ten (10) calendar days from the above date unless:

1. You object in writing to the Iowa Department of Social Services Commissioner Kevin J. Burns and ask for a review within ten (10) calendar days

or

2. The Commissioner, upon the advice of the

Appeals Advisory Committee, decides to review this PROPOSED DECISION, within ten (10) calendar days.

If you or the Commissioner asks to review this decision, you will be given an opportunity to submit further information in writing; you may also request an opportunity to appear in person.

If this PROPOSED DECISION is not reviewed, you will receive a notice when the decision becomes final. If the decision is reviewed, you will receive the FINAL DECISION.

If your assistance is continuing because of your appeal, it will continue until there is a FINAL DECISION

If you do not understand the above process, please contact your local worker for assistance.

A copy of this PROPOSED DECISION will be sent to all concerned parties.

cc: Robert L. Bray, Atty. 609 Ervin Bldg., Council Bluffs, IA 51501

Office of Appeals and Fair Hearings

IOWA DEPARTMENT OF SOCIAL SERVICES

Lucas State Office Building
Des Moines, Iowa 50319

In Re: Darrell Herwig for Elvina Herwig
Polk County

Case No. 372068

Appeal No. 81

Dear Commissioner Burns:

A hearing has been held in the above named case, and I recommend to you the following resolution of this appeal.

PROPOSED DECISION

Findings of Fact

Darrell Herwig appealed the cancellation of Title XIX medical assistance for his wife, Elving Herwig, due to excess income. A notice of Decision dated June 2, 1977, was sent by the Polk County Department of Social Services which stated that Mrs. Herwig's Title XIX Skilled Nursing Care would be cancelled effective June 30, 1977. That Notice of Decision stated as follows:

Due to Manual Letter XII-1-28 (Part Two), no longer able to allow $85 and ⅓ disregard on earned income--only $65 is allowable. This results in your income being above $503 maximum after allowable diversions.

Mrs. Herwig suffered two cerebral hemorages in August, 1977, which left her in a comatose condition. She was determined to be permanently and totally disabled at that time. The Herwig family lives in Council Bluffs, Iowa. An application was made on October 7, 1976, by Mr. Herwig for his wife's hospital care. When Mrs. Herwig could be released from the hospital, it was discovered that there was no skilled nursing facility available in Council Bluffs, and Mrs. Herwig was placed in Des Moines at Americana on November 1, 1976. At the time of Mrs. Herwig's placement in the skilled nursing facility, the Herwig family consisted of Mr. Herwig, Mrs. Herwig, and their four children. Mr. Herwig is employed as a meat cutter with Hinky Dinky. The client participation for Mrs. Herwig's care at the nursing facility has been calculated as follows:

Her client participation for December was based on earnings of $1,256.00
Diversions of 1,133.30
Client Participation 122.70

Diversions were as follows:

($1,256.00 - $65.00 ÷ 2 =	$ 595.50
Earned income	65.00
Spouse ($167.00 + $20.00)	187.80
Children ($65.00 x 4)	260.00
Personal needs	25.00
	$1,133.30

January - March 1977	
Gross Earnings:	$1,256.00
Diversions:	1,068.30
Client participation:	$ 187.70

Diversions decreased due to one daughter now receiving ADC assistance for her baby:

April - June	
Actual Gross Wages	
$314.00 x 4.3 =	$1,350.00
Diversions	1,115.40
Client participation	$ 234.80

Manual Letter XII-1-28 (Part Two) June 3, 1977.

Upon receipt of Manual Letter, client participation was refigured according to letter.

Actual Gross Wages
$5,281.09 ÷ 17 = $310.65
$310.65 x 4.3 = $1,335.80

Diversion for earned income	$ 65.00
Diversion for spouse ($177.80 ÷ 20	197.80
Diversion for 3 dependents at 88.90 x 3	$ 266.70
personal allowance	25.00
	$ 554.50

This figure is above $503 maximum and resulted in cancellation.

	$1,335.80
	554.50
	$ 781.30

The monthly expenses for the Herwig family are as follows:

Client participation	$ 234.80
Groceries (per month)	250.00
House payment (per month)	125.00
Real estate taxes	25.00
Gasoline	28.00
Electricity	37.50
Gas	91.00
Water	21.00
Payments on loan	75.00
TOTAL	$ 887.55

Mrs. Herwig is in need of skilled nursing care 24 hours per day. At the time of the hearing, she was in a semi-conscious state, and unable to do anything for herself. According to Americana, the cost of Mrs. Herwig's care is running

approximately $1,374 per month, this does not include drug or doctor bills. It is only room charge and physical therapy. An application has been made on Mrs. Herwig's behalf for Social Security Disability benefits. A notice was received on June 29, 1977, that Mrs. Herwig would get $25 per month from SSI (Supplemental Security Income).

Because the issue under appeal in this case was one of state law or policy and not one of incorrect grant computation, Mrs. Herwig's Title XIX assistance which had been continued because of her timely appeal, was ordered discontinued, in accordance with 45 CFR 205.10(a)(6)(i)(A).

On July 28, 1977, a temporary restraining order was issued in the United States District Court preventing the Department of Social Services from terminating Mrs. Herwig's Title XIX medical assistance payments pending the outcome of an action filed in that court regarding the Title XIX eligibility.

Conclusions of Law

Prior to July 1, 1977, an earned income disregard of $65 per month plus one-half of the balance of the monthly earned income was allowed by the Iowa Department of Social Services to be diverted for a spouse in the computation of the amount of client participation for a patient in an ICF (Intermediate Care Facility) or SNF (Skilled Nursing Facility). If this computation were used, Mrs. Herwig would continue to be eligible for Title XIX Medical Assistance. According to Iowa Department of Social Services Manual Letter Number XII-1-28 (Part Two), the earned income exclusion will be limited to $65 per month as of July 1, 1977. One half of the balance of the earned income is no longer excluded.

The instructions in this manual letter appear to be in direct conflict with the Federal laws and regulations governing the Medical Assitance program. 45 Code of Federal Regulations 248.3(b)(2)(iii), which provides as follows:

> For determinations of eligibility and amount of assistance of categorically needy aged, blind and disabled individuals, States shall apply the budgeting methodology and applicable dollar amounts set forth in title XVI (SSI) of the Act and 20 CFR Part 416 (with applicable variations to take account of any State Supplementary Payment Program which is federally administered or approved pursuant to 45 CFR 248.2(d) or (e).

Both the SSI law, 42 United States Code 1382a(b)(4)(B) and the Federal Regulations, 20 Code of Federal Regulations Part 416, require that the first $65 per month of earned income plus one-half the remainder of earned income is to be excluded in determining the amount of assistance and eligibility.

It should also be noted that the Federal Regulations governing the Medical Assitance Program, 45 Code of Federal Regulations 248.3(b)(2), appear to

conflict with the Iowa Department of Social Services policies concerning the availability of a spouse's income for Title XIX eligibility and amount of assistance. According to the Federal Regulations, the income and resources of a spouse are to be considered as available to the medical assitance recipient only in the amount which is actually contributed, after the month during which they cease to live together. However, the Iowa Department of Social Services received specific instructions from the State Legislature in the House File 464, Section 18, the appropriation bill for fiscal year 1977-78, to resist implementation of these Federal Regulations. Therefore, this departmental policy has not been changed.

It is recommended that the computation of Mr. Herwig's client participation for the care of his wife be REVERSED, and that the Polk County Department of Social Services be instructed to recompute the amount of his client participation,

disregarding the first $65 of Mr. Herwig's earned income and also disregarding one-half of the remainder of that earned income.

Signed this (11th) day of August, 1977

/s/
(Ms.) Artis Reis,
Hearing Officer

kr

cc: Robert L. Bray, Atty., 609 Ervin Building, Council Bluffs, IA 51501.

IN THE UNITED STATES DISTRICT COURT

FOR THE SOUTHERN DISTRICT OF IOWA

CENTRAL DIVISION

FILED

OCT 7 1977

Clerk, U. S. District Court, Southern District of Iowa

ELVINA M. HERWIG, et al., Plaintiffs,	)
vs.	) CIVIL NO. 77-222-1
ROBERT D. RAY, et al., Defendants.	) STIPULATION

The parties hereto agree and stipulate that the undisputed facts are:

1. Paragraphs 1, 2, 3, 4, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, of Plaintiff's complaint are admitted.
2. Paragraphs 10, 11, 25, 26, 27, 28, 29, 30 are denied by the Defendants.
3. Social Services Manual Letter No. XII-1-28 (Part Two) dated June 3, 1977 attached Plaintiff's amended complaint was in effect at all times relevant.

4. All exhibits attached to Plaintiff's amended complaint are deemed admitted into evidence.

5. The plaintiff may submit an affidavit setting forth his current income and expenses.

6. Defendants maintain that their actions are justified because they are consistent 42 USC 1396a (a)(17).

7. The following briefing schedule is established for the submission of statutory claims.

(a) (a) Both parties shall submit their briefs and arguments by no later than Friday, October 21.

(b) Both parties shall have one week from the filing of briefs to file any replies which they desire.

Dated this (7) day of October, 1977.

/s/
ROBERT L. BRAY
Deputy Director

/s/
STEPHEN C. ROBINSON
Special Assistant Attorney General, Sixth Floor, Lucas Building, Des Moines, Iowa 50319

77

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF IOWA

CENTRAL DIVISION

FILED

OCT 25 1977

Clerk, U. S. District Court, Southern District of Iowa

ELVINA M. HERWEG, by her husband and next friend, DARRELL E. HERWEG, and DARRELL E. HERWEG and all others similarly situated,

Plaintiffs,

vs.

ROBERT D. RAY, et al,

Defendants.

Civil No. 77-222-1

AFFIDAVIT

State of Iowa)
) ss
Pottawattamie County)

DARRELL E. HERWEG, the petitioner herein, being first duly sworn, respectfully states to the court that:

1. On September 1, 1977, he was required to go on sick leave status and was subsequently operated on for cancer of the throat. During the sick leave period, the weekly income of $160 is paid by insurance carried with the

Amalgamated Meatcutters Union 271. The sick leave period is for an indefinite period but could be for as long as one year.

2. The personal expenses of petitioner have been:

House Payment	$125.00 per month
Food	250.00 per month
Clothing	20.00 per month
Transportation	50.00 per month
Medical	20.00 per month
Electricity	34.00 per month
Water	22.00 per month
Gas	91.00 per month
Telephone	10.00 per month
Real Estate Taxes	32.00 per month
Insurance	28.00 per month
Sears	18.00 per month
Penneys	29.50 per month
Bank Loan	75.00 per month

3. The petitioner will no longer have sufficient income to pay all monthly payments and if required to pay on his wife's bills, would be unable to do so.

_____/s/

Subscribed and sworn to before me this (20) day of October, 1977.

Linda Rae Minard /s/
Notary Public

JUDGMENT ON DECISION BY THE COURT

CIV 32 (7-63)

UNITED STATES DISTRICT COURT

FOR THE

SOUTHERN DISTRICT OF IOWA--CENTRAL DIVISION

Civil Action File No. 77-222-1

ELVINA M. HERWEG, by her husband and next friend, DARRELL E. HERWEG; and DARRELL E. HERWEG; and all other similarly situated

vs.

ROBERT D. RAY, individually and in his capacity as Governor of the State of Iowa and KEVIN J. BURNS, individually and in his capacity as Commissioner of the Iowa Department of Social Services

JUDGMENT IN ACCORDANCE WITH THE MEMORANDUM OPINION AND ORDER OF JAN. 19, 1978

This action came on for ~~trial~~ (hearing) before the Court, Honorable William C. Stuart, United States District Judge, presiding, and the issues having been duly ~~tried~~ (heard) and a decision having been duly rendered,

It is Ordered and Adjudged that plaintiffs' request for class action certification is granted;

It is Further Ordered and Adjudged that plaintiffs' request for final determination has been treated by the Court as a motion for Summary Judgment and same is granted;

It is Further Ordered and Adjudged that plaintiffs' request for a permanent injunction against state "deeming" procedures is granted;

It is Further Ordered and Adjudged that any other matters not disposed of in the Opinion and Order will be considered upon application of a party or parties;

It is Further Ordered and Adjudged that costs of this action are assessed against the defendants as of costs accrued of this date.

FILED
FEB 2, 1978

Clerk, U. S. District Court
Southern District of Iowa

Dated at Des Moines, Iowa, this 2nd day of February 2, 1978.

James R. Rosenbaum /s/
Clerk of Court

UNITED STATES COURT OF APPEALS

FOR THE EIGHTH CIRCUIT

No. 78-1664 September Term, 1978

Elvina M. Herweg, etc., et al,	)	
	)	
Appellants,	)	Appeal from the
	)	United States
vs.	)	District Court
	)	for the Southern
Robert D. Ray, etc., et al,	)	District of Iowa.
	)	
Appellees.	)	

The present submission of this appeal to a panel of Judges of the Court on January 12, 1979 is vacated and set aside. On its own motion the Court concludes to re-submit this case to the Court en banc.

The Clerk of this Court is directed to calendar this case for oral argument and submission to the Court en banc on Monday, September 10, 1979.

August 10, 1979

JUDGMENT

UNITED STATES COURT OF APPEALS

FOR THE EIGHTH CIRCUIT

No. 78-1664 September Term, 1979

Elvina M. Herweg, by her husband and next friend, Darrell E. Herweg, and Darrell E. Herweg, and all others similarly situated,

Appellants,

vs.

Robert D. Ray, individually and in his capacity as Governor of the State of Iowa, and Kevin J. Burns, individually and in his capacity as Commissioner of the Iowa Department of Social Services,

Appellees.

FILED
MAY 5 1980
Clerk, U.S. District Court Southern District of Iowa

Appeal From the United States District Court for the Southern District of Iowa

THIS CAUSE came on to be heard on the record from the United States District Court for the Southern District of Iowa and was argued by counsel.

ON CONSIDERATION WHEREOF, it is now here ordered and adjudged by this Court, that the judgment of the said District Court, in this cause, be, and the same is hereby, affirmed except that portion relating to the sources of income the state may consider as available to Medicaid applicants and recipients, which is reversed and remanded.

March 18, 1980

A true copy.

Attest: (Robert D. St Vrain /s/

Clerk, U.S. Court of Appeals, Eighth Circuit

May 2, 1980

Supreme Court, U. S.
FILED
AUG 13 1980
MICHAEL RODAK, JR., CLERK

IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1979

NO. 80-60

ELVINA M. HERWEG, by her husband and next friend, Darrell E. Herweg; and *DARRELL E. HERWEG*, on behalf of themselves and all others similarly situated,

Petitioners,

vs.

ROBERT D. RAY, Individually and in his capacity as Governor of the State of Iowa; and *KEVIN J. BURNS*, individually and in his capacity as Commissioner of the Iowa Department of Social Services,

Respondents.

BRIEF OF RESPONDENTS IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

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IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1979

NO. 80-60

ELVINA M. HERWEG, by her husband and next friend, Darrell E. Herweg; and *DARRELL E. HERWEG*, on behalf of themselves and all others similarly situated,

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vs.

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Respondents.

BRIEF OF RESPONDENTS IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

Respondents Robert D. Ray and Michael V. Reagen, Ph.D., respectfully pray that a writ of certiorari be denied, and that this Court decline to review the judgment of the United States Court of Appeals for the Eighth Circuit entered in this case on March 18, 1980. Petition for rehearing was denied on April 22, 1980. This case is reported at 619 F.2d 1265.

INTRODUCTION

The question presented by the petitioners in their Petition for Writ of Certiorari, pages i-ii is substantially different from the statement of the issue presented for appeal in the United States Court of Appeals for the Eighth Circuit. See page 2, Brief for Appellants in the Eighth Circuit wherein we find:

> The sole issue for review is whether the district court's decision that the incomes of institutionalized and non-institutionalized spouses may be counted together to determine eligibility for Medicaid and the amount of the contribution of the non-institutionalized spouse violates the Medicaid statutes and regulations.

The difference amounts to the submission of a new issue not presented below.

While we recognize that "the sole sanction available to the Secretary of HHS is the cessation of payments to the state.", the Plaintiffs in the instant case had the very real sanction of the power of the district court in contempt proceedings if the respondents failed to abide by the court's decision. Thus, the reference to allowing "the illegal practice to continue" during the process on page 4 of the Petition is inappropriate.

Other than that, the respondents accept the Petitioner's statement of jurisdiction, the statutes and regulations involved, and the statement of the case, in this matter.

REASONS FOR NOT GRANTING THE WRIT OF CERTIORARI

THE EIGHT CIRCUIT'S DECISION AND THE DECISION OF THE DISTRICT COURT CORRECTLY CONSTRUE THE STATUTES INVOLVED, THE CONGRESSIONAL INTENT, AND THE MEDICAID--SSI RELATIONSHIP.

In harmonizing the Medicaid statutes and the SSI statutes, the Court cannot take the "cafeteria" approach in the analysis. That is, the Court cannot pick and choose the law which best suits its taste. It is essential that the Court consider the entire statutes in question, and there have been critical portions that have been ignored by the lower courts which must now be considered. Mr. Justice Rehnquist in Philbrook v. Glodgett, 421 U.S. 707, 713 (1975) stated that:

> [i]n expounding a statute, we must not be guided by a single sentence or member of a sentence, but look at the provision as a whole law and to its object and policy.

In addition to the SSI statute, 42 U.S.C. § 1381 et seq. we must also consider the perintent parts of the Medicaid statute, 42 U.S.C. § 1396a et seq.

Section 1396a(a)(17) provides:

A State plan for medical assistance must--

> (17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of the applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter) as would not be dis-

regarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

The plaintiffs rely on subparagraph (B) while we rely on "unless" clause of subparagraph (D). The entire statute must be read and interpreted as a whole.

In order to understand the Roman numerals used in the above statute, we submit the following table:

Title I 42 U.S.C. § 301 et seq. (1970)
Old Age Assistance (OAA)

Title IV 42 U.S.C. § 601 et seq. (1970)
Aid to Families with Dependent Children (AFDC)

Title X 42 U.S.C. § 1201 et seq. (1970)
Aid to the Blind (AB)

Title XIV 42 U.S.C. § 1351 et seq. (1970)
Aid to the Permanently and Totally Disabled (APTD)

Old
Title XVI 42 U.S.C. § 1381 et seq. (1970)
Aid to the Aged, Blind and Disabled (AABD)

New
Title XVI 42 U.S.C. § 1381 et seq. (Supp. II 1972)
Supplemental Security Income for the Aged, Blind and Disabled (SSI)

Iowa's plan fully complies with subsection (17). Paraphrasing the statute to the facts of the case, the Iowa plan includes reasonable standards for determining eligibility for and the extent of medical assistance under the state plan which (D) shall not take into account the financial responsibility of any individual for any recipient (1) unless it is the individual's spouse or child under age 21, or (2) the person is blind or permanently and totally disabled [if the State provides for eligibility under subchapter XVI

which Iowa does] or the person, (3) is blind and disabled as defined under section 1382c of the United States Code. And with respect to paragraphs A, B, C and D above, provide for flexibility in the application of such standards with respect to income by taking into account the cost (whether in the form of insurance or otherwise) incurred for medical care or for any other type of remedial care recognized under the State plan.

Now, let us consider the legislative history which indicates the intent of Congress. We quote from the S. Rep. 404, reprinted in U.S. Code Cong. & Admin. News, 89th Cong., 1st Session, pp. 1951 and 2018 (1965):

> Eligibility.--...Also where a portion of any deductible or cost sharing required by the voluntary supplementary program is met by a State program, the portion covered must be reasonably related to the individual's income and resources. No income can be imputed to an individual unless actually available; and the financial responsibility of an individual for an applicant may be taken into account only if the applicant is the individual's spouse or child who is under age 21 or blind or disabled.
> * * *
>
> (d) Determination of need for

medical assistance
* * *

> The committee has heard of hardships on certain individuals by requiring them to provide support and to pay for the medical care needed by relatives. The committee believes it is proper to expect spouses to support each other and parents to be held accountable for the support of their minor children and their blind or permanently and totally disabled children even though 21 years of age or older. Such requirements for support may reasonably include the payment by such relative, if able, for medical care. Beyond such degree of relationship, however, requirements imposed are often destructive and harmful to the relationships among members of the family group. Thus, States may not include in their plans provisions for requiring contributions from relatives other than a spouse or the parent of a minor child or children over 21 who are blind or permanently and totally disabled. Any contributions actually made by relatives or friends, or from other sources, will be taken into account by the State in determining whether the individual applying for medical assistance is, in fact, in need of such assistance. [Emphasis added]

In addition to the Medicaid statute, § 1396 et seq., this case involves the Social Security statute pertaining to Supplemental Security Income

(SSI) 42 U.S.C. § 1381 et seq. Judge Ross' opinion (the prevailing opinion in an equally divided court below because it sustained the district court) does a good job of analyzing both statutes involved, as follows:

> Additionally, the SSI statute, § 1382c(f)(1) provides that when an eligible spouse lives with her ineligible spouse, the eligible spouse's income is "deemed to include any income" of the ineligible spouse "whether or not available." Therefore, under the SSI statute there is no need to define the term "available"; its definition is essentially irrelevant. In contrast, the Medicaid statute, § 1396a(a)(17) demands that the standards drawn consider availability, thus, the effort to define "available" must be controlled by the Medicaid statute not the SSI statute.
>
> Although Norman v. St. Clair, supra, and Brown v. Stanton, supra, involved § 209(b) states rather than an SSI-state such as Iowa, it appears that in Norman the Fifth Circuit reached essentially the same result as we do here, by reasoning from the SSI-states' situation to that of a "§ 209(b) state." The court in Norman in discussing the previously cited SSI statute, § 1382 c(f)(1), indicates the following:
>
> "Thus under certain circumstances Medicaid eligibility determinations in an "SSI state" must, because of the

> statutory mandate in the SSI legislation, take into account income that is deemed available, without regard to whether that income is actually contributed. Since this statutory mandate exists concurrently in the Medicaid law with the provision of 42 U.S.C. § 1396 a(a)(17) directing that only income which is "available" be taken into account, it must be concluded that the income deemed to Medicaid applicants pursuant to provisions of law applicable to SSI states is available income which includes income deemed to spouses in SSI states must also encompass income deemed[6] to spouses in the more restrictive programs of the § 209(b) states."

At 1238. [619 F.2d at 1274]

The Petitioners indicate that this case stands alone in its interpretation of the applicable law. We agree there is a divergence of case law authority on this subject, but we insist the courts below were correct. District Judge Stuart stated in the instant case:

> This Court joins other courts in holding that state procedures which "deem" a computed portion of a spouse's income to be available for an institutionalized spouse's expenses by application of an arbitrary formula are contrary to 42 U.S.C. § 1396a(a)(17) as shown by its language and the expressed congressional intent.

443 F.Supp. at 1319.

The key words are "computed portion" and "by application of an arbitrary formula". This leads to Judge Stuart's mandate that "a factual determination in each instance" be made to determine "the amount of the spouse's income which is in fact reasonably available for the support of the institutionalized spouse." 443 F.Supp. at 1319.

The first decision interpreting the controlling statute is Franssen v. Juras, 406 F.Supp. 1375 (D.Ore. 1975). We frankly adopt the opinion of Circuit Judge Goodwin (dissenting) where at pp. 1380-81, we find:

> ...The state subtracts from the gross income and resources of the non-institutionalized spouse the basic welfare standard and imputes the remainder to the institutionalized spouse. While it may be myopic for the state to disregard certain financial dislocations inherent in living apart, as well as the realistic cost of car repairs and mortgage payments, this myopia is not inconsistent with the federal scheme. Federal regulations comtemplate precisely such a computational technique in analogous evaluations of gross income available to "medically needy" aid recipients or applicants. See 45 C.F.R. § 248.21(a)(3)(i)-(ii) (1973). The same method surely cannot be so "unreasonable" here as to confound the state scheme under the Supremacy Clause.

* * *

The more difficult issue is whether the "actually available" language of regulations implementing 42 U.S.C. § 1396a(a)(17)(B) cancels out, in effect, the provision of § 1396a (a)(17)(D) permitting states to take certain relative responsibilities into account.

The plaintiffs have conceded that since financial eligiblity for Medicaid is determined by requirements of the categorical assistance programs, the exceptions built into those programs with respect to the presumption of availability of income and resources apply for the purpose of determining the amount of medical assistance. The effect of this concession is to temper the seemingly absolute prohibition against imputation of income not actually made available which emerges from a strict reading of 42 U.S.C. § 1396a(a)(17)(B), the legislative history of this provision, and 42 C.F.R. § 248.21(a)(2)(i) (1973). Imputation is proper, then, when the spouse of an aid recipient is "living with him in the same household." 42 U.S.C. § 1382c(f)(1).

The next question is whether this exception is to be read literally to preclude imputation when one spouse is institutionalized. The plaintiffs urge that spousal income imputation should be strictly limited to the situation where spouses are living

> together in the same physical space. They argue that imputation is rational in this situation alone because (1) only when two spouses physically live together do they enjoy economies of scale such as shared rent, and (2) only when they physically live together is actual sharing sufficiently probable to justify the presumption.
> * * *
>
> The plaintiffs make no showing that the likelihood of actual sharing is significantly reduced by an involuntary separation resulting from the institutionalization of one spouse.
>
> It is more plausible to read the exception as continuing to apply even after such involuntary separations. If the spouses are physically living together in the same household immediately prior to the institutionalization of one spouse, then the institutionalization must be viewed as a temporary absence from home necessitated by illness. Any other interpretation would allow the non-institutionalized spouse to thwart at will the policy of 42 U.S.C. § 1396a(a)(17)(D), which permits states to take into account spouses' financial responsibility to one another. [Emphasis added]

Judge Stuart quoted from the Franssen majority at p. 1319 of 443 F.Supp. that the "prohibition against assuming sources of income is not in-

tended to permit one spouse to spurn a normal obligation to support and assist the other merely by refusing to make contributions." 406 F.Supp. at 1378. The majority stated that nothing in their decision would prevent Oregon from reenacting a relative responsibility law and making it applicable to Medicaid. This is not only a cumbersome, after-the-fact method, but also, a cruel and ineffective method. If a person qualifies and is eligible for aid, why go back later and sue under a relative responsibility statute? Congress did not intend this! Congress addressed this issue in subpart (D) of subsection (17) and the courts ought to give proper recognition to this part of the statute as it relates to the whole. The Herwegs fit squarely within the "unless" clause of this portion of the law.

Burns v. Vowell, 424 F.Supp. 1135 (S.D.Tex. 1976), is a preliminary injunctive action challenging the Texas Medicaid regulations. Again, this is a case the Petitioners usually cite. At p. 1141 of 424 F.Supp., we note:

> At the hearing, Plaintiffs' counsel represented that Mr. Burns would be willing and able to pay up to $152.00 toward Mrs. Burns' care rather than the $394.00 which Defendant has de-

> manded, but at this point in the proceedings the Court is not going to attempt to treat the question of reasonable allocation of financial responsibility on an ineligible noninstitutionalized spouse, or the question of what are the proper procedures for the State to employ.

Judge Stuart's order, of course, "treats the question of reasonable allocation" and the proper procedure for the state to employ. The manual materials and methods of calculations were specifically considered. The Plaintiffs want deeming in reverse. That is, by employing a simple formula, they would conclude that income was not available. This was rejected by Judge Stuart:

> However, it seems to the Court that "deeming" is contrary to Congressional intent whether income of the noninstitutionalized spouse is deemed available or unavailable. [Emphasis added] [443 F.Supp. at 1320]

The plaintiffs are unwilling to accept the concept that "deeming" is a two-way street. We submit the District Court is right. We cannot assume that income is unavailable simply because a spouse refuses to pay a nursing home bill. Most elderly people want to pay their bills.

Judge Stuart's order provides for a case by case determination to make sure that such payment is fair and equitable.

In Manfredi v. Maber, 435 F.Supp. 1106 (D.Conn. 1977), the Court wisely avoids the use of the word "deeming". The phrase "interspousal income attribution" is not much of an improvement, however. Perhaps we should simply use the statutory language and recognize that the financial responsibility of an individual will be taken into consideration when dealing with a spouse. The buzz word "deeming" is not adequate to convey the intent of Congress as express in this statute pertaining to medicaid. The Court concludes that Connecticut's interspousal income attribution regulations are arbitrary. 435 F.Supp. at 1115. Judge Stuart's order in the instant case answers this by the individual factual determination. This complies with the statute.

For other reasons why the District Court's opinion is correct, we return to Judge Ross' opinion in the Eighth Circuit:

> There are also additional reasons for finding SSI eligibility requirements inapplicable to the institutionalized spouse situation. In the institutionalized spouse sit-

uation there is a "gap", which as we will explain, has been closed by states such as Iowa, by electing to cover optional groups.

Congress apparently linked SSI and Medicaid because a person who needs financial assistance to live (SSI) would naturally need financial assistance for medical care. However, under 42 U.S.C. § 1382(e)(1)(B)(i) the maximum SSI benefit payable to an institutionalized individual who does not have an eligible spouse is $300 per year or $25 per month reduced by non-excluded income. Congress authorized this amount for institutionalized individuals "to enable them to purchase small comfort items not supplied by the institution." H.R. Rep.No. 92-231, 92nd Cong., 2d Sess. 3, reprinted in [1972] U.S.Code Cong. & Admin.News, pp. 4989, 5136. However, since the $25 payment is reduced by nonexcluded income, it seems apparent that many institutionalized individuals would not be eligible for SSI benefits although they would be in dire need of Medicaid. This "gap" in the SSI-Medicaid scheme was remedied by providing that a state may provide Medicaid coverage to optional groups, including (1) those who are SSI eligible but do not receive benefits, 42 C.F.R. § 435.210; (2) those who are ineligible for SSI because of lower income standards used to determine eligibility for institutionalized

individuals, but who would be SSI eligible if not institutionalized, 42 C.F.R. § 435.211; and (3) institutionalized individuals who are not SSI eligible but who have income below a certain level. 42 C.F.R. § 435.231 (federal funds are available only for those persons whose income is below 300 percent of the SSI individual benefit amount, 42 C.F.R. § 435.1005).

In the situation where states such as Iowa elect to provide medical coverage to optional groups, some of whom are not eligible to receive SSI benefits, we find the rigid and costly imposition of unreasonable SSI regulations inappropriate and unfair to the taxpayer and welfare recipients of the state. Each state is limited in the total amount its legislature will appropriate. If it is forced to pay the entire cost of institutionalizing a person whose spouse has more income that he reasonably needs, optional coverage will of necessity be reduced or eliminated in other areas. [Emphasis added. [619 F.2d at 1275]

We note that the Petitioners, (p. 30 Petition for Writ of Certiorari) say that the state "can drop coverage of the optional categorically needy,..." This is not in the best interest of the aged, blind or disabled nor is it consistent with the statutory provisions

which, of course, express the Congressional intent.

CONCLUSION

For the reasons presented above, a writ should not issue.

Respectfully submitted,

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No. 80-60

In the Supreme Court of the United States

OCTOBER TERM, 1980

ELVINA M. HERWEG, ET AL., PETITIONERS

v.

ROBERT D. RAY, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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In the Supreme Court of the United States

OCTOBER TERM, 1980

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ELVINA M. HERWEG, ET AL., PETITIONERS

v.

ROBERT D. RAY, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

QUESTION PRESENTED

Whether the district court correctly concluded, contrary to regulations of the Department of Health and Human Services, that Iowa may consider income as "available" to an applicant for benefits under the Medicaid Act in circumstances where that income would not be considered in determining eligibility for Supplemental Security Income benefits.

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3 Medicare and Medicaid Guide (CCH) ¶ 15,586 (July 23, 1980) 15
45 Fed. Reg. 82254 (1980) 9

This brief is filed in response to the Court's invitation to the Solicitor General to express the views of the United States.

STATEMENT

1. The Medicaid program was established in Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae*, No. 79-1268 (June 30, 1980), slip op. 1-2. As adopted in 1965, Title XIX only required participating states to provide medical assistance to individuals who received cash assistance under one of the four "categorically needy" assistance programs established in the Social Security Act.[1] See 42 U.S.C. (1970 ed.) 1396a(a)(10). Under Section 1902(a)(17) of the Act, 42 U.S.C. (1970 ed.) 1396a(a)(17), each participating state was required to adopt "reasonable standards * * * for determining eligibility for and the extent of medical assistance" and to take into account "only such income and resources as are * * * available to the applicant or recipient." Congress also required participating states to refrain from taking into account "the financial responsibility of any individual for any applicant or recipient of assistance * * * unless such applicant or recipient is such individual's spouse" or minor, blind, or disabled child. 42 U.S.C. (1970 ed.) 1396a(a)(17)(D).

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[1] Old Age Assistance, Title I, 42 U.S.C. (1970 ed.) 301 *et seq.*; Aid to Families with Dependent Children, Title IV, 42 U.S.C. (1970 ed.) 601 *et seq.*; Aid to the Blind, Title X, 42 U.S.C. (1970 ed.) 1201 *et seq.*; Aid to the Permanently and Totally Disabled, Title XIV, 42 U.S.C. (1970 ed.) 1351 *et seq.*

With the approval of the Secretary of Health, Education, and Welfare (now Health and Human Services), some participating states took the position that it was reasonable to expect an applicant's spouse to help pay the cost of the applicant's medical expenses and, therefore, adopted rules that took into account the spouse's income in determining Medicaid eligibility and the amount of assistance. These states calculated an amount considered necessary to pay the basic living expenses of the applicant's spouse and "deemed" any income of the spouse in excess of that amount "available" to the applicant.

In 1972, Congress replaced three of the four categorical assistance programs with a new federal program, Supplemental Security Income for the Aged, Blind, and Disabled (SSI), 42 U.S.C. 1381 *et seq.*[2] As noted, from the inception of the Medicaid program in 1965, participating states were only required to provide medical assistance to those individuals receiving cash assistance under one of the categorical assistance programs. Participating states were also entitled to receive federal financial assistance under the Medicaid program if they chose to provide medical assistance to the "medically needy," *i.e.*, certain individuals who satisfied specified income requirements after incurred medical expenses were deducted from their income. See 42 U.S.C. (1970 ed.) 1396a (a)(10)(B). Adoption of the SSI program was not intended to affect the traditional linkage between

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[2] As its name indicates, the SSI program replaced the categorical assistance plans for the aged, blind, and disabled. The provisions of the old categorical assistance programs remain effective in Puerto Rico, Guam, and the Virgin Islands. See Pub. L. No. 92-603, Title III, Sections 303(a) and (b), 86 Stat. 1484.

categorical assistance eligibility and Medicaid eligibility. See 42 U.S.C. 1396a(a)(10)(A), (C), and 1396d(a); see also 42 U.S.C. 1383c.

Under the SSI program, however, the states would no longer control the standards of need for the aged, blind, and disabled. In some states, the group of individuals that would be eligible for SSI assistance, and consequently eligible for Medicaid assistance, was significantly larger than the group of individuals that was eligible under the old assistance programs for the aged, blind, and disabled. Participating states would, therefore, have been forced to: (1) expand their Medicaid assistance obligations involuntarily, (2) withdraw from the Medicaid program, or (3) reduce the level of benefits provided under their Medicaid plans. To avoid these consequences, Congress offered the states what has come to be called the "209(b) option," which allows each state either to accept the expanded Medicaid obligations resulting from adoption of the SSI program or to limit Medicaid eligibility to the group of individuals who would have been eligible for assistance under the state Medicaid plan on January 1, 1972. 42 U.S.C. 1396a(f).[3]

The income of an applicant's spouse is attributed to the applicant for the purpose of determining eligibility and the amount of assistance under the SSI program. When the applicant and his spouse share a single home, the income of both is considered in detemining the eligibility of either. 42 U.S.C. 1382a(a), 1382c(b), (f)(1). If the applicant and his spouse cease to share the same household, the income of the applicant's spouse is considered only if the spouse

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[3] The provision was enacted as Section 209(b) of the Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1381.

is an "eligible spouse." 42 U.S.C. 1382c(b).[4] By definition, an applicant's spouse cannot remain an "eligible spouse" for more than six months after the separation. *Ibid.*

Any state that participates in the Medicaid program but fails to exercise the 209(b) option (an "SSI state") is specifically required to provide medical assistance to all SSI benefit recipients. 42 U.S.C. 1396a(a)(10)(A). The Secretary's regulations make explicit what is implicit in the relationship of the Medicaid and SSI statutes, by requiring all SSI states to consider the income of an applicant's spouse in making Medicaid determinations only to the extent that the income would be considered under the SSI statute. 42 C.F.R. 435.723, 435.700. Based on the relationship between the Medicaid and SSI statutes, but taking into account Congress' purpose in adopting the 209(b) option, the Secretary also issued parallel regulations applicable in 209(b) jurisdictions. 42 C.F.R. 435.734.

2. Petitioners filed this class action in the United States District Court for the Southern District of Iowa, challenging the provisions of the Iowa Medicaid Plan that permit consideration of the income of an applicant's spouse. Iowa is an SSI state, but under its Medicaid program in effect at the time of suit a "formula" was used for determining the portion of the income of an applicant's spouse that was "available" to the applicant, apparently without regard to the length of time the applicant and his spouse had been separated (see Pet. App. 76a-77a, 86a). Petitioners argued that the Iowa practice was inconsistent

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[4] For administrative reasons, if the applicant and his ineligible spouse separate in the middle of a particular month, the income of the spouse is considered until the end of that month.

with both the requirements of Section 1902(a)(17) of the Act, 42 U.S.C. 1396a(a)(17), and applicable HHS regulations, 42 C.F.R. 435.723 (Pet. App. 79a).[5] Petitioners also argued that the Iowa procedures violated (i) the Equal Protection Clause of the Fourteenth Amendment because they irrationally discriminated against married institutionalized Medicaid applicants and (ii) the Due Process Clause of the Fourteenth Amendment because they created an "irrebutable presumption" that the spouse is able to pay the amount computed by the formula and that the money is "actually available" to the applicant (Pet. App. 80a).[6]

Relying on Section 1902(a)(17), the district court held that Iowa could consider the income of an applicant's spouse in making Medicaid determinations, but only after making individualized factual inquiries to determine the amount of the spouse's income that should be attributed to the applicant. The court did not find that the amount of the income attributed to the named plaintiff was unreasonable or unduly burdensome: "the operation of the [Iowa] formula as finally computed appears to make a reasonable allocation of income in the situation before the Court"; but the court attributed that fact to "mere[] coinciden[ce]" (Pet. App. 85a). According to the district court, Section 1902(a)(17) requires individual factual determinations in every case of what income is "available" (Pet. App. 85a). In addition, the district

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[5] At the time the complaint was filed, the applicable HHS regulation was codified at 45 C.F.R. 248.3(b) (1976).

[6] The district court's reference to the Due Process Clause of the Fifth Amendment (Pet. App. 80a) is erroneous. In any event, the district court did not reach the constitutional claims (Pet. App. 87a), apparently taking the position that its statutory holding eliminated the basis for the constitutional claims.

court concluded that the Iowa procedure was inconsistent with the HHS regulations (*id.* at 86a), but that the regulations themselves were inconsistent with the statute (*id.* at 87a). Because HHS was not a party to the litigation, the district court thought it inappropriate to hold the regulations invalid (*ibid.*).

In response to the district court's decision, Iowa adopted a procedure for making individual factual determinations of the amount of income of an applicant's spouse that is "available" for Medicaid purposes. Petitioners objected and sought clarification of the district court's order, taking the position that none of the income of an applicant's spouse could be attributed to the applicant unless it was actually contributed (see Pet. App. 90a-91a). Applicable HHS regulations require this result after the applicant and his spouse have been separated for one month if the applicant's spouse is not an "eligible spouse," as defined in 42 U.S.C. 1382c(b).[7] Nevertheless, the district court ignored the HHS regulations and "specifically approved" (Pet. App. 94a) the procedure adopted by Iowa. Although the court acknowledged that the position urged by petitioners "might be possible under the relevant statutes," it concluded that "[t]he existence of alternative procedures is irrelevant" (*id.* at 92a). The court also held that, in making Medicaid determinations, Iowa must disregard the receipt of Social Security benefits, Railroad Retirement Board annuities, and Civil Service Commission annuities (*id.* at 90a, 92a).

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[7] As noted above, no one can remain an "eligible spouse" for more than six months. Therefore, after an applicant and his spouse have been separated for more than six months, HHS regulations require the result contended for by petitioners in the district court.

The court of appeals affirmed in part and reversed in part (Pet. App. 1a-75a). Sitting en banc, the Eighth Circuit affirmed by an equally divided court that part of the district court decision requiring Iowa to make individual factual determinations of available income for Medicaid purposes without regard to the time limitations imposed by the HHS regulations (*id.* at 2a). The court of appeals unanimously reversed the district court's holding that Iowa must disregard Social Security benefits, Railroad Retirement Board annuities, and Civil Service annuities in making Medicaid computations (*id.* at 2a, 28a, 74a).

DISCUSSION

1. The decision of the court of appeals in this case is one of four recent circuit court decisions concerning deeming practices under the Medicaid Act. See *Gray Panthers* v. *Administrator, Health Care Financing Administration*, 629 F.2d 180 (D.C. Cir. 1980), petition for cert. pending, No. 80-756 (filed Nov. 10, 1980); *Brown* v. *Stanton*, 617 F.2d 1224 (7th Cir. 1980), petition for cert. pending, No. 79-1690; *Norman* v. *St. Clair*, 610 F.2d 1228 (5th Cir. 1980), petition for cert. pending, No. 80-498 (filed Sept. 27, 1980).[8] Each of these decisions is to some

[8] See also *Allen* v. *Califano*, Civ. No. 78-0212 (D. Utah Aug. 23, 1979), appeal pending, No. 79-2167 (10th Cir.) (ordering the Secretary to rescind 42 C.F.R. 435.734 and to issue regulations that require 209(b) states, Guam, Puerto Rico, and the Virgin Islands "to cease assuming the availability of any income that is not in fact available for any length of time" (Order at 2). Appellate proceedings in *Allen* have been stayed pending consideration of the Secretary's petition for a writ of certiorari in *Harris* v. *Gray Panthers*, No. 80-756, but the Tenth Circuit refused to stay the district court's

extent irreconcilable with the others. Although the Eighth Circuit's decision in this case is the first to consider deeming in an SSI state, it, like the other decisions, is based, at least in part, on an interpretation of the term "available" income, as used in the Medicaid statute, and constitutes a rejection of the Secretary's analysis of the relationship between the Medicaid and SSI statutes.[9]

Like the cases involving deeming in 209(b) jurisdictions, this case has significant implications for every state in the nation except Arizona, which has no Medicaid program. Participating states are free to elect or forego the Section 209(b) option at their discretion. Misssissippi, formerly a 209(b) jurisdiction, has decided to become an SSI state effective July 1981. See Miss. Ann. Code § 43-13-115 (1972), as amended in Mississippi Senate Bill No. 2118 (May 21, 1980). New York, formerly an SSI state, has recently decided to exercise the 209(b) option. Other states are free to follow. Medicaid is a nationwide program, under which billions of dollars are paid on behalf of millions of individuals each year.[10] It is the

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order pending appeal. The government has filed a petition for reconsideration of the order denying the motion to stay the *Allen* order pending appeal.

[9] We therefore disagree with petitioners' suggestion (Pet. 17; see id. at 18) that this case is significantly different from those cases involving deeming in 209(b) jurisdictions. With respect to both SSI and 209(b) jurisdictions, the pertinent HHS regulations were based upon the Secretary's analysis of the relevant statutes and were issued pursuant to her authority to prescribe the standards for determining "available" income under the Medicaid statute, 42 U.S.C. 1396a(a)(17)(B).

[10] See petition for a writ of certiorari in *Harris* v. *Gray Panthers*, No. 80-756, at 10-11.

Secretary's responsibility to require participating states to provide medical assistance to each qualified applicant with a minimum of administrative delay and cost and to assure that participating states do not receive federal financial assistance for providing medical assistance to any applicant who is not among the intended beneficiaries of the Medicaid program. Because of the conflicting decisions of the courts of appeals, the Secretary now must follow different rules in different SSI and 209(b) states concerning whether "deeming" is permissible at all and, if it is, in what manner and for how long may it be used.

The Eighth Circuit is the only court of appeals to have considered deeming in a case involving an SSI state. Nevertheless, both the Fifth Circuit and the D.C. Circuit have accepted the Secretary's view that the relationship between the Medicaid and SSI statutes requires SSI states to consider the income of an applicant's spouse as available to the applicant only to the extent that it would be considered in determining SSI eligibility. See *Norman* v. *St. Clair*, *supra*, 610 F.2d at 1238; *Gray Panthers* v. *Administrator*, *supra*, 629 F.2d at 183. Thus, although there is no direct conflict among the courts of appeals on this point, the Secretary currently is faced with three inconsistent decisions concerning the proper relationship between the Medicaid and SSI programs in regard to the determination of "available" income.[11]

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[11] Pursuant to the decision in *Gray Panthers* v. *Administrator*, the Secretary recently issued regulations that prohibit 209(b) jurisdictions from considering the income of an applicant's spouse as "available" to the applicant unless it would be considered in determining SSI eligibility. 45 Fed. Reg. 82254 (1980). The effect of the decisions in this case and *Gray Panthers*, therefore, is to permit Iowa, an SSI state, to consider the income of an applicant's spouse even though

This Term the Court will have the opportunity to resolve the conflict in the circuits as to whether deeming is permissible under the Medicaid Act. See *Brown* v. *Stanton*, *supra*. If deeming is permissible, it is important that the appropriate procedure for deeming and the permissible limitations on the practice be settled as expeditiously as possible. This case squarely raises the third issue, and incidentally presents the first and second issues as well.

2. The district court's decision is plainly contrary to valid HHS regulations. In an SSI state, after the first month in which the applicant and his ineligible spouse have been separated, only income that is "actually contributed" to the applicant by his spouse may be considered "available" under the regulations. 42 C.F.R. 435.700, 435.723. Yet, the district court's order directs Iowa to consider the income of an applicant's spouse as "available" indefinitely, so long as the determination of available income is made after an individual hearing. As Judge Ross observed (Pet. App. 10a-11a), "there is no dispute that the new procedure approved by the district court is contrary to regulation [42 C.F.R.] 435.723." Respondents do not deny that their current procedure is contrary to the HHS regulations; rather, they ignore the regulations and argue that the district court's interpretation of the statute is correct (see Br. in Opp. 15-16).

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that income would not be considered in determining SSI eligibility, but to prohibit 209(b) states from doing so. This turns the statutory scheme created by Congress on its head and frustrates Congress' purpose in enacting the 209(b) option.

Under Section 1902(a)(17)(B) of the Act, however, the Secretary is explicitly authorized to prescribe standards for determining what income is "available" to a Medicaid applicant. 42 U.S.C. 1396a (a)(17)(B). Therefore, unless those regulations are arbitrary, capricious, or otherwise unlawful, they must be given legislative effect. See *Batterton* v. *Francis*, 432 U.S. 416, 425-426 (1977).

The HHS regulations that govern in this case are based on the Secretary's sound analysis of the interrelationship of two complex social welfare statutes. States that participate in the Medicaid program but fail to exercise the 209(b) option (see 42 U.S.C. 1396a(f)) must provide medical assistance to all individuals who are SSI recipients. 42 U.S.C. 1396a (a)(10)(A); 42 C.F.R. 435.120. It follows, therefore, that as to this group an SSI state cannot be allowed to consider the income of a Medicaid applicant's spouse as "available" to the applicant if the income would not be considered in determining eligibility or the amount of assistance under the SSI statute. See 42 C.F.R. 435.700. With carefully limited exceptions,[12] no SSI state is entitled to federal financial assistance for providing medical assistance to aged, blind, or disabled individuals who do not meet SSI income limitations.

To the extent relevant here, SSI states may receive federal financial assistance for providing medical assistance to: (1) individuals who would be eligible for SSI benefits or an optional state supplement, if

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[12] See, *e.g.*, 42 C.F.R. 435.122, 435.130, 435.131, 435.132, 435.133, 435.134, 435.135, 435.210, 435.211, 435.230, 435.231, 435.301. Iowa does not have a "medically needy" program, and therefore it is unnecessary in this case to consider the regulations applicable to the "medically needy."

they applied, 42 C.F.R. 435.210;[13] (2) individuals who would be eligible for SSI or an optional state supplement if they were not institutionalized and therefore subject to lower income standards, 42 C.F.R. 435.211; and (3) if the state chooses to provide Medicaid coverage to the group that would be eligible for SSI or state supplemental payments but for institutionalization, then the state may also provide Medicaid assistance to the group of institutionalized individuals who would be ineligible for benefits under either the SSI program or the state supplement program even if they were not institutionalized, 42 C.F.R. 435.231.[14] Each of these groups is defined in part by reference to SSI income limitations. It follows, therefore, that the same method of calculating income under the SSI statute must be

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[13] Under Section 1616 of the Act, a state may make cash payments to certain individuals "as assistance based on need in supplementation of [SSI] benefits (as determined by the Secretary [of HHS])." 42 U.S.C. 1382e(a). Although the state may set higher income limitations than those applicable under the SSI statute, the state is only entitled to federal financial assistance for providing Medicaid coverage to these individuals if their gross income is no more than 300% of the SSI benefit amount (*i.e.*, 300% of the SSI income eligibility standard). See 42 U.S.C. 1396b(f)(4)(C); 42 C.F.R. 435.230, 435.1006. Furthermore, the state may only provide medical assistance to supplemental payment recipients who are receiving SSI benefits "or who would but for [excessive] income be eligible to receive such benefits." 42 U.S.C. 1396d(j).

[14] But, as observed above concerning Medicaid coverage of state supplement recipients generally (note 13, *supra*), a participating state is entitled to federal financial assistance for providing medical assistance to a member of this group only if his gross income is not in excess of 300% of the SSI benefit amount. See 42 C.F.R. 435.231(2), 435.1005.

used in calculating income for purposes of determining whether a state is entitled to receive federal financial assistance for providing medical assistance to an individual pursuant to one of these options.[16] Thus, the HHS regulations requiring SSI states to consider income of an applicant's spouse as "available" to the applicant, in determining Medicaid eligibility under one of these three options, to the same extent that it would be considered in determining SSI eligibility (42 C.F.R. 435.723) are not only reasonable, they are "compelled by the relationship between the SSI and the Medicaid programs" (Pet. App. 61a-62a; McMillian, J., dissenting).

There is nothing in the plain language of Section 1902(a)(17) of the Act that requires a contrary result or that can support the holding of the district court. The statute does not speak to the question of

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[16] For example, if a state decides to provide Medicaid coverage to individuals who would be eligible for state supplemental payments if they filed applications, it is entitled to federal financial assistance for providing medical assistance to an individual in this group only if his gross income does not exceed 300% of the SSI benefit amount. See 42 C.F.R. 435.210, 435.230, 435.1006. If the state may ignore income that would be considered in determining SSI eligibility, then the 300% limitation is rendered meaningless and the state may receive federal financial assistance for providing medical assistance to individuals whose income is greatly in excess of that limitation. On the other hand, if the state includes income that would be ignored under the SSI program, individuals who should be covered under this category will be improperly denied assistance. For example, an individual who would be eligible for SSI benefits if he applied is necessarily eligible for state supplemental payments. Yet, if the state, in determining Medicaid eligibility, may include income that is ignored for purposes of SSI, this individual may be denied medical assistance.

what income is "available." Rather, Congress specifically authorized the Secretary to define the term "available" income for the purpose of determining Medicaid eligibility. Section 1902(a)(17) cannot reasonably be read to permit participating states to ignore the standards for determining available income that it specifically authorizes the Secretary to prescribe. Congress obviously did not regard the meaning of the term "available income" as self-evident. The district court offered no reason for rejecting the Secretary's regulations, other than its disagreement with the Secretary's interpretation of the term "available." But Congress has left the interpretation of that term to the Secretary and not the courts. "A reviewing court is not free to set aside those regulations simply because it would have interpreted the statute in a different manner." [16] *Batterton* v. *Francis*, *supra*, 432 U.S. at 425.

3. The decision in this case seriously misapprehends the relationship between the Medicaid and SSI statutes. Having failed to exercise the 209(b) option, Iowa is statutorily required to provide Medicaid coverage to all SSI recipients. 42 U.S.C. 1396a(a)(10)(A); 42 C.F.R. 435.120. The income of an applicant's ineligible spouse is not considered for pur-

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[16] For the same reason, the district court erred in requiring Iowa to conduct individualized factual inquiries to determine what income is "available" to the applicant. The Secretary's regulations do not require individualized hearings and there is nothing in the term "available" income that suggests that the only permissible way of making the determination is by conducting such hearings. Compare, *e.g.*, *Califano* v. *Jobst*, 434 U.S. 47, 53 (1977). A similar issue is raised in the Secretary's petition for a writ of certiorari in *Harris* v. *Norman*, No. 80-498, at 9-14.

poses of determining SSI eligibility after an applicant has been institutionalized for one month. See 42 U.S.C. 1382(a)(1), 1382c(b), (f)(1); 42 C.F.R. 435.723(d). Hence, as the Secretary's regulations provide, such income may not be considered beyond the one-month period in determining eligibility for or the amount of Medicaid benefits.

If, as in the named petitioner's case, the applicant has no income of his own and is in a private institution, he is eligible for SSI benefits. If such an applicant applies and receives SSI benefits, then in an SSI state he would also be entitled to Medicaid benefits. Yet, under the district court's order, Iowa may deny Medicaid benefits to such an applicant if, after making an individual factual determination, Iowa concludes that the income of the spouse should be considered available in an amount greater than the SSI limitations.[17]

Although Mrs. Herweg was not an SSI recipient, the district court certified a class comprising (Pet. App. 87a):

> all married couples residing in Iowa of which: (1) one spouse is eligible for Medicaid and requires institutionalization; and (2) the other spouse is not institutionalized; and (3) the non-institutionalized spouse has income which is, under current state procedures, being deemed available to the institutionalized spouse.

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[17] Mrs. Herweg was not an SSI recipient, but the same analysis is appropriate with respect to an individual who would be eligible if he applied (42 C.F.R. 435.210, 435.723) or would be eligible but for his institutionalization (42 C.F.R. 435.211, 435.723), assuming, of course, that the state chooses to cover these groups, as Iowa has (see 3 Medicare and Medicaid Guide (CCH) ¶ 15,586 at 6543 (July 23, 1980)).

That class is on its face not limited to non-SSI recipients. Furthermore, the new Iowa deeming procedure, which was specifically approved by the district court, is by its terms applicable "to all applicants/recipients in a Title XIX Medical Institution who: 1. Have a non-institutionalized spouse * * * and 2. The non-institutionalized spouse * * * [is] ineligible for SSI * * *."[18] Thus, the district court's decision seems to require Iowa to adopt procedures that violate both the Secretary's regulations and the explicit command of Section 1902(a)(10)(A) of the Act, 42 U.S.C. 1396a(a)(10)(A). This decision warrants further review.

[18] State of Iowa, Department of Social Services, Des Moines, Social Services Manual Letter No. 37, at 1-2. See also *id.* at 8 (contemplating application of the new procedure to SSI recipients).

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1980

ELVINA M. HERWEG, by her husband and next friend, Darrell E. Herweg; and DARRELL E. HERWEG, on behalf of themselves and all others similarly situated,

Petitioners,

vs.

ROBERT D. RAY, individually and in his capacity as Governor of the State of Iowa; and KEVIN J. BURNS, individually and in his capacity as Commissioner of the Iowa Department of Social Services,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

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QUESTION PRESENTED

Whether the court of appeals correctly invalidated a federal regulation which was promulgated by the Secretary of the Department of Health and Human Services pursuant to explicit statutory authority to define the income "available" to applicants for Medicaid and which was designed to effect the relationship between the Medicaid and Supplemental Security Income statutes.

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IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1980

No. 80-60

ELVINA M. HERWEG, by her husband and next friend, Darrell E. Herweg; and DARRELL E. HERWEG, on behalf of themselves and all others similarly situated,

Petitioners,

vs.

ROBERT D. RAY, individually and in his capacity as Governor of the State of Iowa; and KEVIN J. BURNS, individually and in his capacity as Commissioner of the Iowa Department of Social Services,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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BRIEF FOR PETITIONERS

OPINIONS BELOW

The court of appeals, sitting en banc, filed two opinions. That of Judge Ross (Pet.App. 3a-31a) is reported at 619 F.2d 1267. Judge McMillian's (Pet.App. 31a-75a) is reported at 619 F.2d 1276. The district court's Memorandum Opinion and Order of January 19, 1978 (Pet.App. 76a-88a) appears at 443 F.Supp. 1315; its Ruling and Order of July 10, 1978 (89a-96a) is reported at 481 F.Supp. 914. The Final Judgment of August 4, 1978 (Pet.App. 97a-98a) is not reported.

JURISDICTION

The judgment of the court of appeals (J.S. 83-84) was entered on March 18, 1980. On April 22, 1980, a timely petition for rehearing was denied (Pet.App. 99a-100a). The petition for certiorari was filed on July 14, 1980 and was

granted on July 2, 1981. The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

STATUTES AND REGULATIONS

The relevant statutes, sections 1902(a)(10), 1902(a)(17), and 1902(f) of the Social Security Act, and the regulation at issue, 42 C.F.R. §435.723, are reprinted verbatim at Pet.App. 101a-107a.

STATEMENT OF THE CASE

1. The Medical Assistance program, commonly known as Medicaid, was established in 1965 as Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq. It provides "federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." Harris v. McRae, 448 U.S. 297,

301, 100 S.Ct. 2671, 2680 (1980); Schweiker v. Gray Panthers, 453 U.S. --, 101 S.Ct. 2633, 2636 (1981). The program is jointly financed by the federal and state governments, and administered by the states. Herweg v. Ray, 619 F.2d 1265, 1277 (8th Cir. 1980) (McMillian, J., concurring in part and dissenting in part) (Pet.App. 34a).[1/] In Iowa's case, the reimbursement formula results in payment to the state of over 55% of its incurred costs. 42 U.S.C. §1396b; 44 Fed. Reg. 10553 (1979); 45 Fed.Reg. 79582 (1980).

If a state chooses to participate in the voluntary program, it must submit a

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1/ For the sake of convenience, petitioners will hereinafter refer to Judge Ross' decision, which resulted in affirmance of the district court, as the "Ross Op.," while that written by Judge McMillian will be termed the "McM. Op."

state plan to the Secretary of Health and Human Services ("HHS") for approval. 42 U.S.C. §1396a. "State Medicaid plans must comply with requirements imposed by the [Social Security] Act itself and by the Secretary of Health and Human Services ...." Schweiker v. Gray Panthers, supra, 101 S.Ct., at 2636; Harris v. McRae, supra, 448 U.S., at 301, 100 S.Ct., at 2680; see also 42 U.S.C. §§1396a(b), 1396b.

A key element of the federal Medicaid scheme is the flexibility which it permits the states. Although a state must develop its plan within the guidelines established by federal statute and regulations, it has numerous options available to it in devising the precise contours. States are required to provide assistance to the "categorically needy", who are those

meeting the categorical definitions of age, blindness, disability or childhood dependency, and who are considered eligible for assistance from the Aid to Families with Dependent Children program, 42 U.S.C. §601 et seq., or from the Supplemental Security Income ("SSI") program, 42 U.S.C. §1381 et seq., for the aged, blind, and disabled. Schweiker v. Gray Panthers, supra, 101 S.Ct., at 2636; Harris v. McRae, supra, 448 U.S., at 301 n.1, 100 S.Ct., at 2680 n.1; see 42 U.S.C. §1396a(a)(10)(A); 42 C.F.R. §435.4.

Even this basic requirement, however, is replete with options and refinements. States were given the alternative of providing categorically needy coverage only to those aged, blind, and disabled who would have been eligible under the state's

plan in effect on January 1, 1972. 42 U.S.C. §1396a(f); Schweiker v. Gray Panthers, supra, 101 S.Ct., at 2637-2638. Selection of this so-called "§209(b) option" releases a state from the obligation of automatically covering all SSI recipients, and thus allows it to tailor its program to its particular fiscal needs. Id., at 2637.

In addition, Congress has established the optional categorically needy. 42 U.S.C. §1396a(a)(10)(III); 42 C.F.R. §435.200 et seq. These are limited groups to which a state can extend categorically needy coverage; although they do not actually receive SSI cash assistance, they are either eligible for them or are considered eligible for them. See McM. Op., 619 F.2d, at 1284 (Pet. App. 52a-53a); S.Rep.No. 93-553, 93d Cong., 1st Sess. 58 (1973).

Finally, the state may extend eligibility to the medically needy, who also are within one of the four defined categories, but who, unlike the categorically needy, have income or recources too high to qualify for cash assistance. Beltran v. Myers, 101 S.Ct. 1961, 1962 n.1 (1981); Harris v. McRae, supra, 448 U.S., at 301 n.1, 100 S.Ct., at 2680 n.1; see 42 U.S.C. §1396a(a)(10)(C); 42 C.F.R. §435.4. The medically needy establish their eligibility by spending down on medical costs to established levels. 42 C.F.R. §435.301; see, e.g., Hogan v. Harris, 501 F.Supp. 1129, 1131-1132 (D.Mass.1980), on appeal, No. 81-213 (Jur. Stmt. filed July 31, 1981). States which extend assistance to the medically needy have been required to extend it to all individuals satisfying the statutory definition, 42 U.S.C. §1396a(a)(10)(C)(i), while they can selectively

extend categorically needy coverage to specifically defined groups of the optional categorically needy. McM. Op., 619 F.2d, at 1284 (Pet.App. 53a). The medically needy are further distinguished from the categorically needy because states are not required to provide the same services to the two classifications. Compare 42 U.S.C. §1396a(a)(13)(C) with 42 U.S.C. §1396a(a)(13)(B); see Harris v. McRae, supra, 448 U.S., at 301 n.1, 100 S.Ct., at 2680 n.1.[2/]

2/ On August 13, 1981, President Reagan signed into law the "Omnibus Budget Reconciliation Act of 1981," Pub.L. No. 97-35, 95 Stat. --. Section 2171 of the Act replaces the previous section 1902(a)(10)(C) of the Social Security Act, 42 U.S.C. §1396a(a)(10)(C), with a new paragraph (C). This new provision allows states to provide medically needy coverage on a more selective basis. See H.Rep. No. 97-208, 97th Cong., 1st Sess. 970-971 (1981). The Act makes only slight, irrelevant changes to section 1902(a)(10)(A), see H.Rep. No. 97-208, supra, at 479-480,

(cont. p. 10)

Iowa chose not to cover the medically needy. Moreover, it has elected to premise coverage of the aged, blind, and disabled on the SSI statute; it does not, therefore, have the flexibility of §209(b) states, which may employ eligibility conditions more restrictive than those used by the "SSI states". 42 U.S.C. §1396a(f); 42 C.F.R. §435.121. Iowa has chosen, however, to extend coverage to some optional categorically needy. Because they are categorically needy, however, the state is not required to extend coverage to any others. See McM.Op., 619 F.2d, at 1284 (Pet. App. 53a).

2. Having opted not to be a §209(b)

2/ (cont.)
and makes no changes to either the §209(b) option or the optional categorically needy. Since Iowa does not have a medically needy program, infra, at 10, this amendment is irrelevant to this case.

state, Iowa was therefore subject to the Medicaid rules applicable to the SSI states. For several years after SSI was implemented on January 1, 1974, the relationship between SSI and Medicaid was not fleshed out by HHS. It is apparent that some SSI states continued to use eligibility conditions which were more restrictive than permitted under SSI.[3/] Additionally, because some SSI states contracted with the Social Security Administration for the latter to determine the eligibility of its categorically needy, see 42 U.S.C. §1383c; 20 C.F.R. §416.2101 et seq., situations were arising whereby an individual was

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3/ For example, both Oregon and Texas were and are SSI states, yet both were using rules for determining Medicaid eligibility after 1973 which were not premised on SSI. See Franssen v. Juras, 406 F.Supp. 1375 (D.Ore.1975); Burns v. Vowell, 424 F.Supp. 1135 (S.D.Tex.1976).

certified as categorically eligible by SSA, but was found ineligible under state rules. See 40 Fed.Reg. 60074 (1975) (1st col.).

Concerned with these and other inconsistencies, and anxious to "ensure uniformity and equity in Medicaid eligibility determinations ... in accord with the applicable statutory and regulatory provisions," id., at 60074 (2d col.), the Secretary proposed amended regulations on December 31, 1975. 40 Fed.Reg. 60074. The new regulations, designed to replace those then codified at 45 C.F.R. §248.3(b), set out "the rule for use of SSI policy in determining the availability of the income and resources of spouses and parents for aged, blind and disabled applicants in States using Title XVI eligibility criteria." Id.,

at 60074 (2d col., ¶4). Like all interested parties, Iowa and other states were offered the opportunity to comment on these proposed regulations. Id., at 60074 (3d col.).

The regulations were later published in final form, with an effective date of April 13, 1977. 42 Fed.Reg. 2684 (1977). The explanation of the regulations discussed their purpose and responded to comments which had been offered about the proposed regulations. HHS reiterated the need for "uniformity and equity in Medicaid eligibility determinations", id., at 2684 (1st col.), and again noted that the relationship between the Medicaid and SSI statutes required the use of SSI eligibility criteria.4/

4/ "Thus, relatives whose incomes are looked to and counted in determining SSI eligibility in certain living arrangements must also be looked to and have their incomes counted in Medicaid eligibility determinations by the State; conversely, where relatives' incomes are not counted, or cease
(cont. p. 14)

Significantly, HHS also noted that the "new regulations constitute such standards of availability prescribed by the Secretary" pursuant to the express directive in the Medicaid statute, 42 U.S.C. §1396a(a)(17)(B). 42 Fed.Reg. 2684 (2d col.).

The explanation of the new regulations described in detail how the limited periods for imputing income available between separated spouses were derived. Id., at 2685. They were based on provisions of the SSI statute which required the incomes of eligible spouses to be counted as one while they were living together, and for six months after they separated, while the incomes of spouses where only one was eligible were considered individually as soon

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4/ (cont.)

to be counted in certain living arrangements, Medicaid-only eligibility determinations must do likewise." 42 Fed.Reg. 2684 (2d col.).

as they separated. Id., at 2685 (1st col.). The Medicaid regulation developed for the SSI states thus specifically reflected these distinctions between the treatment of couples' income based on the spouses' eligibility and the period of separation. See 45 C.F.R. §248.3(b)(2) (1977).[5/] In effect, the regulations required the states to treat the spouses as separate economic units after expiration of the one- or six-month periods of separation. The combining, imputing, or deeming of income was forbidden at those points. See Schweiker v. Gray Panthers, supra, 101 S.Ct., at 2638.

5/ The regulation was later renumbered as 42 C.F.R. §448.3(b). 42 Fed.Reg. 52827 (1977). A year later, HHS rewrote and recodified, but without "policy" or "substantive" changes, its Medicaid regulations. Those discussed in this case became 42 C.F.R. §435.723. 43 Fed.Reg. 45176, 45177 (1978). See Norman v. St. Clair, 610 F.2d 1228, 1235 & n.12 (5th Cir. 1980), cert. denied sub nom. Schweiker v. Norman, 101 S.Ct. 3159 (1981).

HHS considered the comments from states concerned about "the cost impact [which] the proposed regulations would have on the State Medicaid programs." 42 Fed.Reg. 2685 (2d col.).[6/] HHS specifically rejected these and other arguments on several grounds. First, the financial impact on the states was not as great, HHS noted, as on individuals subjected to deeming. Moreover, there were not many people involved, and, in any event, the regulations did not forbid the states from enforcing relative responsibility laws to collect contributions. Id., at 2685 (2d col., Response 1). HHS also repeatedly stated that the limitation on deeming was required in the SSI states by the relationship between the statutes; only those

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6/ The record does not reflect whether Iowa or its Department of Social Services filed such a comment.

selecting the §209(b) option were released from that obligation. Id., at 2686 (1st col., Responses 5, 6, 7). The agency thus explained in detail why its regulations were a necessary incident of statutory requirements, and implied that states with objections should select the alternative basis for determining the eligibility of the aged, blind and disabled.

Iowa, and at least one other state, Florida, selected a different course: they proposed to continue unlimited deeming without becoming SSI states.[7/] Iowa's action was deliberate and explicit. The Iowa General Assembly instructed the State

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7/ Florida's illegal action was enjoined shortly thereafter because of its failure to comply with controlling federal law. Griswold v. Page, [1977] Medicare & Medicaid Guide (CCH) ¶28,537 (N.D.Fla.1977). The district court in that case found the federal regulations controlling, and did not suggest or imply that those regulations might not comport with the federal statute.

Department of Social Services to "resist the implementation" of the new federal regulations. House File 464, section 18, Acts of the 67th General Assembly (J.A. 48). The Department complied by issuing its Manual Letter No. XII-1-28 (part 2) on June 3, 1977 (J.A. 36). See Herweg v. Ray, 443 F.Supp., at 1316-1317 (Pet.App. 76a).

Pursuant to this directive, a portion of the income of the non-institutionalized spouse, computed by use of an arbitrary formula which did not take into account the individual needs and expenses of that spouse, was assumed, or deemed, available to the institutionalized spouse without regard to whether the deemed amount accurately reflected the financial situation of the non-institutionalized spouse and to whether the non-institutionalized

in fact made the contribution. The Iowa policy, thus, ignored the express HHS directive that the income of one spouse could not be considered available to the other at the conclusion of the stated periods.

HHS was unsuccessful in inducing Iowa to comply. In a letter to the HHS regional commissioner in Kansas City on June 15, 1977, defendant Burns defended Iowa's position on the grounds that "[w]e have determined that the revised regulations ... are not in the best interest of the state or its citizens." The letter noted, inter alia, that the federal regulations would "serve to increase expenditures" and "further compounds the complexity of an eligibility process which is already burdensome and once again unilaterally passes costs on to the state without adequately

assessing the impact of such action upon individual programs." (J.A. 50-54) These contentions had already been considered and rejected by HHS during the comment period. Moreover, defendant Burns made no effort to defend the state's policy on legal grounds; there is no explanation as to why defendants believed that their policy complied with federal law or that the HHS regulations did not.

3. Elvina Herweg, who had been married to Darrell Herweg since July 30, 1949, suffered aneurisms and cerebral hemorrhages on both sides of her head in August, 1976. She has since remained in a comatose state, permanently and totally disabled. On her behalf, Darrell Herweg applied for medical assistance, which was granted, effective October 7, 1976. She was placed in a long term care facility on November 1, 1976,

and her husband applied for and received medical assistance for her care in that facility. (J.A. 25-27, 76.) Herweg v. Ray, 443 F.Supp., at 1316-1317 (Pet.App. 77a).[8/]

At the time of the filing of the complaint, Mr. Herweg, a butcher in Council Bluffs, Iowa, had a monthly net income of $1032.00, on which he was supporting three teenage daughters. Mrs. Herweg had no income of her own. Pursuant to the Department's initial calculations, he made monthly contributions to the cost of her care of $234.80 in April, May, and June, 1977. This payment left him with insufficient income to meet his family's expenses. (J.A. 27, 76, 79.) On June 2,

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8/ The essential facts of the Herwegs' situation, as well as defendants' policy and refusal to comply with federal regulations, were stipulated to by the parties. Unless otherwise stated, all factual statements are supported by the stipulation. (J.A. 76.)

1977, the Department issued a new Notice of Decision, based on the revised state method for calculating available income set out in the Manual Letter. (J.A. 27, 55, 76.) It set aside $197.00 per month as a "diversion" for Mr. Herweg, $266.70 for the three daughters, and $25 as a personal allowance for Mrs. Herweg; $65 as earned income was exempted. The rest of his gross income, over $800, was considered available to her; as this amount was over the eligibility standard for a nursing home resident, Mrs. Herweg was determined ineligible, effective June 30, 1977.[9/]

9/ As Judge McMillian noted, 619 F. 2d, at 1290-91 (Pet.App. 69a-74a), Mrs. Herweg's complete impoverishment made her eligible for SSI benefits. Had she applied, she would have been found eligible within a month of entering the institution. She did not apply, however, and thus was not actually receiving SSI benefits.

Later, after the court granted a Temporary Restraining Order, the Department issued a new "Proposed Decision" based on a different calculation. Under this determination, she was found eligible, but an arbitrary portion of his income was still deemed available to her. (J.A. 28, 65, 76.) If he failed to pay that amount, her "eviction would be imminent." Herweg v. Ray, 443 F.Supp., at 1317 (Pet.App. 79a).

4. After the June 2, 1977 decision of the local welfare office was affirmed by the state, this case, brought as a class action, was filed in district court. With the causes of action brought under 42 U.S.C. §1983, jurisdiction was alleged under 28 U.S.C. §1343 and 28 U.S.C. §1331.[10/]

10/ The district court found jurisdiction under both of these provisions, 443 F.Supp., at 1316 (Pet.App. 77a), and the court of appeals noted jurisdiction under §1343(3). Ross.Op., 619 F.2d, at 1269 (Pet.App. 8a-10a).

Plaintiffs filed an amended complaint on September 15, 1977, in which they elaborated on their arguments. Plaintiffs raised both statutory and constitutional claims, with their lead allegation being that the policy required by the state legislature and implemented by the Department violated the federal regulation [then 45 C.F.R. §248.3(b)]. Based on the parties' stipulation to the material facts (J.A. 76), and the affidavit of Darrell Herweg (J.A. 78), the court issued its initial decision on January 19, 1978, granting summary judgment to plaintiffs. Judge Stuart recognized that federal law places limitations on the eligibility criteria which states may impose, 443 F. Supp., at 1318 (Pet.App. 81a), and he therefore concluded that the Medicaid statute, 42 U.S.C. §1396a(a)(17), forbade

a state from deeming "a computed portion of a spouse's income to be available for an institutionalized spouse's expenses by the application of an arbitrary formula ...." Id., at 1319 (Pet.App. 83a). At the same time, the court also acknowledged that a state could seek a contribution from the non-institutionalized spouse, id., at 1319 (Pet.App. 83a-84a), but did not indicate how this contribution could be effected. The court held Manual Letter No. XII-1-28 (part 2) invalid. Id., at 1319 (Pet.App. 85a).

The district court also evaluated Iowa's policy in light of the federal regulations, and held it invalid under those regulations as well. 443 F.Supp., at 1320 (Pet.App. 86a). The court was quick to point out that it was not "approving the amended [federal] regulations," but that it was "not appropriate to make a

finding on the validity of that section [of the regulations]." Id., at 1320 (Pet. App. 87a). Despite this determination that the Iowa policy violated the federal regulations, the court simultaneously held that the state should make an individualized determination of available income, which could "be required as a contribution to the support of the institutionalized spouse." Id., at 1320 (Pet.App. 87a). Since the applicable federal regulation does not permit a state to deem any amount after the first month of institutionalization, this additional conclusion appeared to contradict the determination that the state policy was in violation of the regulations.[11/]

11/ The court declined to rule on plaintiff's constitutional claims. Those claims were not before the court of appeals, nor are they before this Court. See Schweiker v. Gray Panthers, supra, 101 S.Ct., at 2639 n.11, 2643 n.23.

The parties requested the court to further explain its holding, and plaintiffs raised other issues as well. On July 10, 1978, the court issued an additional "Ruling and Order." 481 F.Supp. 914 (Pet.App. 89a). First, Judge Stuart held that the "anti-alienation" provisions of the Social Security, Railroad Retirement, and Civil Service Retirement Acts[12/] required that benefits from these programs be disregarded in calculating the income of the non-institutionalized spouse. 481 F.Supp., at 916 (Pet.App. 90a). Secondly, he clarified his previous holding by accepting the state's revised procedures, under which the state would still be imputing income from one spouse to the other. The court was satisfied with the

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12/ Respectively: 42 U.S.C. §407; 45 U.S.C. §231m; 5 U.S.C. §8346(a).

state's new procedure requiring individualized determinations of appropriate contributions, and concluded that it did not violate the requirements of 42 U.S.C. §1396a(a)(17). Id., at 917 (Pet. 91a-92a). Finally, the court agreed that defendants should notify the members of the plaintiff class of their right to obtain reimbursement of amounts improperly deemed from them in the past. Id., at 917-918 (Pet. App. 93a-96a).

In its final judgment dated August 4, 1978, the court incorporated its prior decisions (Pet.App. 97a-98a). From that judgment, plaintiff appealed, contending that regardless of whether and how an individualized determination was made, the state was still not permitted under federal law to assume that contributions would in fact be made. The original submission of

the appeal to a panel of the Eighth Circuit was vacated sua sponte by that court, which ordered the case to be re-argued en banc. (J.A. 82.) At the same time, the court requested the Department of Health and Human Services to submit a brief amicus curiae "specifically" directed at the validity of "the regulation at issue [42 C.F.R. §435.723(d)] ...." HHS complied with that request.

In the court of appeals' order and decision of March 18, 1980, the district court's judgment on the issue of deeming was "affirmed by an equally divided court ...." 619 F.2d, at 1267 (Pet.App. 2a).13/

13/ All eight members of the court, however, reversed the district court's decision forbidding consideration of government benefits because of "anti-alienation" provisions. 619 F.2d, at 1267, 1275, 1292 (Pet.App. 2a, 28a, 74a). Defendants had

(cont. p. 30)

Both Judges Ross and McMillian acknowledged that the issue which they were resolving was the propriety of the federal regulations. Judge Ross, for instance, noted that "there is no dispute that the new [state] procedure approved by the district court is contrary to regulation, [42 C.F.R.] §435.723." 619 F.2d, at 1269 (Pet.App. 10a-11a). Thus, both opinions were directed not at a determination of whether the state procedure failed to comply with federal law, which had been the issue presented to the district court, but, rather, with whether the federal regulation was an appropriate interpretation of the federal statute.

13/ (cont.)
not appealed that or any other aspect of the district court's judgment nor had either party or HHS discussed that issue in any briefs to the court of appeals or at either oral argument.

The court's disagreements were initially and significantly evident in their discussions of the appropriate standard by which to evaluate the regulation promulgated by HHS. Judge Ross relied on the general presumption in favor of the construction of the responsible federal agency, but with emphasis on the proviso that the court should not rubber-stamp those decisions. 619 F.2d, at 1270 (Pet. App. 13a-14a). As an apparent afterthought, he rejected the notion that the explicit delegation to the Secretary to define "available" requires the Secretary to be upheld unless that decision is arbitrary, capricious, an abuse of discretion, or otherwise illegal. 619 F.2d, at 1272 n.4 (Pet.App. 18a-19a).[14/]

14/ Judge Ross stated alternatively that "even under the narrower test of

(cont. p. 32)

By contrast, Judge McMillian recognized the applicability of the Batterton test to this case through the delegation to the Secretary in 42 U.S.C. §1396a(a)(17)(B). He therefore summarized the task before the court in this manner: "This question before us is whether the regulation is proper, not how the statutory term should be interpreted." 619 F.2d, at 1277 (Pet.App. 32a) (emphasis in original). Judge McMillian thus directed his attention not at devising the best possible interpretation of the statutory terms, but at determining whether the Secretary's interpretation was a

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14/ (cont.)

Batterton [v. Francis, 432 U.S. 416 (1977)], we would hold that the regulation must fall." 619 F.2d, at 1272 n.4 (Pet.App. 19a). But he offered no analysis in support of this conclusion, and applied all of his reasoning to an explanation of why his interpretation of the statute was preferable to the Secretary's.

legitimate one. See Schweiker v. Gray Panthers, supra, 101 S.Ct., at 2640.[15/]

Judge Ross' substantive analysis was primarily based on an interpretation of 42 U.S.C. §1396a(a)(17). He reasoned that

> "the term 'available' in §1396a(a)(17) when read in conjunction with the legislative history cannot by any stretch of the imagination be translated into the 'actually contributed' language of the current regulation .... In effect [HHS] has substituted the words 'actually contributed' for the statutory word 'available.'" 619 F.2d, at 1271-1272 (Pet.App. 17a-18a).

As further support for his position, he relied on the language of §1396a(a)(17)(D), which allows "a state to consider the financial responsibility of a spouse in determining eligibility." Id., at 1272 (Pet.App. 18a).

15/ Judge McMillian added that the Secretary's interpretation was indeed the better one. 619 F.2d, at 1277 (Pet.App. 33a).

Although Judge Ross acknowledged the link between SSI and Medicaid, he rejected its logical and necessary impact in this situation. Finding no SSI provision requiring use of the term "actually contributed" to define "available", he determined that the provisions on which HHS relied for the regulation provided no basis for that construction. 619 F.2d, at 1273 (Pet.App. 23a-24a). Moreover, he concluded that existence of the optional categorically needy provided an additional rationale for not following the requirements of the link. Id., at 1274-1275 (Pet.App. 26a-27a). He failed to explain, however, how the link between the two statutes could possibly result in applying a different rule for determining Medicaid eligibility than for determining SSI eligibility, regardless of whether the

categorically needy are limited to actual cash recipients or include those deemed to be cash recipients. To a significant extent, Judge Ross, like the Iowa General Assembly, rested his legal conclusion on the irrelevant assumption that the federal regulation would result in an unwarranted increase in expenditure to the states. Id., at 1275 (Pet.App. 27a).

Judge McMillian, however, recognized the pivotal role of the link between the two statutes: "[T]he deeming regulation is based upon SSI eligibility criteria and is mandated by the Medicaid statute itself, which defines Medicaid eligibility by referring to SSI eligibility." Id., at 1278 (Pet.App. 37a). This generally recognized integration of the SSI rules into the Medicaid program necessarily resulted in applying limitations to some aspects of

Medicaid eligibility; thus, the recognition of spousal responsibility in §1396a (a)(17)(D) was not repudiated by the HHS regulation, as Judge Ross determined, but was, rather, limited by it. Id., at 1280 (Pet.App. 40a-42a). The overall treatment of separated spouses, Judge McMillian concluded, must be determined by both the Medicaid and SSI statutes, not just by the former, which is solely applicable only in §209(b) states. Id., at 1280, 1287 (Pet. App. 43a, 61a-62a). As a consequence, the method by which the income of a spouse is counted, or not counted, as available to the other in SSI determinations must necessarily be applied in the Medicaid context as well. The regulations implemented this goal; indeed, they were necessary to achieve this goal. Id., at 1287 (Pet.App. 61a-62a). Unlike Judge Ross, therefore,

Judge McMillian fully accepted the basic and definitive premise of an "SSI state": "Medicaid eligibility in an SSI state is premised upon SSI eligibility." Id., at 1289 (Pet.App. 65a).

In short, the court of appeals' opinions present two strikingly different views of both the appropriate standard for review and the appropriate interpretation of the statutory provisions. Judge Ross rejected the significance of the congressional directive to the Secretary to define "available". He also repudiated the premise on which Congress established the relationship between the SSI and Medicaid. Judge McMillian recognized that the court's only obligation was to determine whether the Secretary's interpretation is appropriate, and concluded that the definitive link between the two programs required

the Secretary to develop regulations for Medicaid which were derived directly from the SSI statute.

SUMMARY OF ARGUMENT

I. It is undisputed that the Iowa regulation challenged in this case conflicts with the federal regulation. If the latter is valid, then the former must fall. The issue before this court, therefore, is the validity of the federal regulation.

That regulation, 42 C.F.R. § 435.723, was promulgated by the Secretary of Health and Human Services pursuant to an explicit directive in the Medicaid statute, 42 U.S.C. § 1396a(a)(17)(B), that the Secretary define "available" income and resources. This Court has recently held that paragraph (17)(B) requires the Secretary's interpretation to be given "legislative effect". Schweiker v. Gray Panthers, 101 S.Ct. 2633,

2640 (1981). In light of the standard which flows from that extraordinary deference to the Secretary, the Court's only role is to ensure that the federal regulation is not arbitrary or capricious. Batterton v. Francis, 432 U.S. 416, 426 (1977).

II. Since the federal regulation is reasonable, it must be upheld and the state regulation must be found invalid.

A. Although this Court just considered the Secretary's interpretation of "available" in the Gray Panthers case, the substantive determination there does not control in this case. The issue there was deeming in the § 209(b) states, whereas here, the issue is "deeming" in the SSI states. The former, by definition, have considerably greater flexibility, as this Court has recognized. Schweiker v. Gray Panthers, supra, 101 S.Ct., at 2637-2638.

The determination that unlimited deeming was permissible in those states has no applicability to the regulation here at issue.

B. The federal regulation at issue permits deeming in the SSI states, but limits it to certain periods of time. See id., at 2638. By contrast, the regulation applicable in the § 209(b) states is not tied to the SSI statute and therefore has no time limitations.

C. The Secretary has always based the deeming regulation for SSI states on the "SSI-Medicaid link", 42 U.S.C. § 1396a(a)(10)(A), which requires an SSI state to provide Medicaid to the categorically needy. This automatic dependence of Medicaid eligibility on SSI eligibility has been regularly acknowledged by the courts; as this Court observed in Gray Panthers, it was specifically because of this dependence that Congress offered states the more

flexible approach inherent in the § 209(b) option. Id., at 2637-2638.

The deeming rules in the SSI states derive from the statutorily required treatment of income in the SSI program. The Secretary has determined that the time limits from that program must, because of the "link", be read into the Medicaid program. Pursuant to his statutory directive, therefore, the Secretary defines "available" in light of the SSI requirements.

Neither the defendants nor the courts below have presented any arguments that the Secretary's regulation, which is entitled to "legislative effect", is arbitrary or capricious. One suggestion below, however, was that the regulation violates 42 U.S.C. § 1396a(a)(17)(D), which permits states to take into account the financial responsibility of spouses. But

that section is not mandatory, and, in any event, the regulation does not repudiate that provision. Deeming is permitted for limited time periods; moreover, as the Secretary has noted, the states are still allowed to enforce responsibility through other methods. The Secretary has not nullified paragraph (D), but has balanced it with other requirements of the statute.

The court below also cited the words "actually contributed" in the regulation as indicative of error on the Secretary's part. But the precise language is irrelevant, for the only important factor is whether the regulation effectuates the goal of limiting deeming to the same extent that is required in the SSI program. And that goal is accomplished through the language chosen by the Secretary.

The explicit language of paragraph (17)(B), as recently explained by this

Court, requires the Secretary's regulation to be given "legislative effect". The Secretary has balanced the various factors, and the result is consistent with the statute. Since the state rule is in conflict, it must be held invalid.

ARGUMENT

I. THE FEDERAL REGULATION, 42 C.F.R. § 435.723, IS ENTITLED TO LEGISLATIVE EFFECT.

The issue of this case is a conflict between federal regulations defining Medicaid deeming in SSI states and Iowa's own deeming rules. The district court below, as well as the court of appeals by virtue of an equally divided en banc court, approved of Iowa's "deeming" procedures even though "there is no dispute . . . [that it] is contrary to regulation [42 C.F.R.] § 435.723". Ross Op., 619 F.2d, at 1269 (Pet.App. 10a-11a). Given this inherent conflict, Iowa can succeed only if the federal regulations are determined to be void; conversely, if the federal regulations are valid, Iowa's procedures

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must be invalid.[16/]

The regulation on which this case hinges, 42 C.F.R. § 435.723, was promulgated by the Secretary under the authority of 42 U.S.C. § 1396a(a)(17)(B). Paragraph (B) sets forth in relevant part that states providing Medicaid benefits must consider an applicant's "income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant." (Emphasis supplied.)

16/ This Court has long recognized that states which participate in federal-state cooperative programs under the Social Security Act must comply with federal requirements when accepting federal dollars. E.g., Townsend v. Swank, 404 U.S. 282, 286 (1971). Thus, "[s]tate Medicaid plans must comply with requirements imposed both by the Act itself and by the Secretary of Health and Human Services . . . ." Schweiker v. Gray Panthers, supra, 101 S.Ct., at 2636 (emphasis supplied). Iowa is therefore bound to follow federal Medicaid regulations as long as it participates in the program.

Just last Term, this Court, relying on Batterton v. Francis, 432 U.S. 416 (1977), analyzed the broad authority of the Secretary to prescribe regulations under this provision:

> "In view of this explicit delegation of substantive authority, the Secretary's definition of the term 'available' is 'entitled to more than mere deference or weight.' Batterton v. Francis, supra, 432 U.S., at 426, 97 S.Ct., at 2406. Rather, the Secretary's definition is entitled to 'legislative effect' because, '[i]n a situation of this kind, Congress entrusts to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term.' Id., at 425, 97 S.Ct., at 2405. Although we do not abdicate review in these circumstances, our task is the limited one of ensuring that the Secretary did not 'excee[d] his statutory authority' and that the regulation is not arbitrary or capricious. Id., at 426, 97 S.Ct., at 2406." Schweiker v. Gray Panthers, supra, 101

S.Ct., at 2640.

The Batterton standard controls the focus for evaluating the conflict between Iowa's deeming procedures and the federal government's rules. Under Batterton's "legislative effect" rule, the court must weigh only the reasonableness of the Secretary's regulation. If the regulation meets that test, it is valid and the inquiry is at an end. As Judge McMillian correctly noted below: "[T]he question is whether the federal regulation itself is a reasonable interpretation of the statutory provision." 619 F.2d, at 1277 (Pet.App. 33a).17/

17/ Judge McMillian, although not having the benefit of this Court's analysis in Gray Panthers, used virtually identical reasoning to support his application of the Batterton standard in this case. Judge Ross, on the other hand, not only questioned the applicability of Batterton, but effectively ignored the standard. Judge Ross did note, after attempting to distinguish

Employing the Batterton/Gray Panthers analysis does not, contrary to Iowa's assertion below, require an in-depth analysis of the reasonableness of Iowa's deeming rules. Even were the conclusion warranted, it would not be relevant that Iowa's

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Footnote 17 continued.

Batterton, that he would strike down the HHS regulations, even under the narrow Batterton test, 619 F.2d at 1272 n. 4 (Pet.App. 19a n. 4). Nevertheless, Judge Ross' opinion belies that statement.

First, he made no findings or conclusions consistent with the Batterton analysis. Nowhere, for example, does Judge Ross conclude that HHS' regulations are either arbitrary or capricious.

Second, his minimal deference to Batterton appears at best to be an afterthought. Well before his "Batterton footnote", Judge Ross relies on pre-Batterton cases, such as Red Lion Broadcasting Co. v. FCC, 395 U.S. 367 (1969), which use the "deference to the agency" standard. Use of this "mere deference" approach, however, ignores this Court's directions that regulations under 42 U.S.C. § 1396a(a)(17)(B) are entitled to much greater weight -- i.e., legislative effect. Schweiker v. Gray Panthers, supra, 101 S.Ct., at 2640.

interpretation of the federal statute is also rational or consistent with congressional intent: "Whether or not the federal regulation is less reasonable than the state's regulation is beside the point." McM. Op., 619 F.2d, at 1277 (Pet.App. 33a).

Given the weight accorded federal regulations adopted under section 1396a(a)(17)(B), it is sufficient for this court to determine that those regulations are not arbitrary. Consideration of Iowa's statutory analysis justifying its rules, as is offered by Judge Ross, is not a proper focus for this Court. Instead, the issue, as set forth by Judge McMillian and confirmed in Gray Panthers, is simply whether the Secretary's definition of the term "available" in 42 C.F.R. § 435.723 is arbitrary and capricious. Schweiker v. Gray Panthers, supra, 101 S.Ct., at

2640.[18]

II. THE FEDERAL REGULATION, 42 C.F.R. § 435.723, IS REASONABLE AND NOT ARBITRARY OR CAPRICIOUS.

A. The Substantive Determination In Gray Panthers Is Relevant But Not Controlling.

The validity of Iowa's deeming rules, as shown above, turns on the validity of the controlling HHS regulations. This Court's decision last Term in Gray Panthers is determinative of the standard to be applied in evaluating regulations promulgated pursuant to 42 U.S.C. § 1396a(a)(17)(B). However, the specific regulations

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18/ As this Court also noted in Gray Panthers, 101 S.Ct., at 2640, another issue under Batterton is whether the Secretary has "exceeded his statutory authority." In this case, however, "neither party argues that the Secretary has exceeded her authority in promulgating this regulation". McM. Op., 619 F.2d, at 1278 (Pet.App. 37a).

before the Court in this matter, 42 C.F.R. § 435.723, were not at issue in Gray Panthers.

The Gray Panthers case concerned only the validity of HHS deeming regulations applicable to § 209(b) states. See 42 U.S.C. § 1396a(f). As previously noted, states participating in the Medicaid program have an option of using their 1972 eligibility rules (§ 209(b) states) or the SSI rules (SSI states). "States thus became either 'SSI states' or '§ 209(b) states' depending on the coverage that they offered." Schweiker v. Gray Panthers, supra, 101 S.Ct., at 2638 (footnote omitted).

Furthermore, as this Court noted in Gray Panthers, the Secretary permits states to "change from 'SSI-status' to '§ 209(b)-status' at any time." Id., at 2638 n. 6. Fifteen states presently use the § 209(b)

option; therefore, they may undertake deeming to the extent permissible under their 1972 eligibility rules. The federal regulations for these states, which, by definition, ignore SSI rules, authorize "[g]reater 'deeming'" than for SSI states. "[I]f they choose, § 209(b) states may 'deem' to the full extent that they did before 1972." Id., at 2638 (citation omitted). Only the regulations applicable to the § 209(b) states, 42 C.F.R. § 435.734, were considered in Gray Panthers.

By contrast, the present case concerns the corresponding regulation authorizing deeming in the SSI states. As this Court has already noted, the extent of deeming allowed in SSI states differs from that allowed in § 209(b) states.[19/]

19/ This Court has resolved in Gray Panthers the issue of whether the statutory underpinnings of the regulations, 42 U.S.C. § 1396a(a)(17)(B) and (D), permit deeming.

Thus, the only question now before the Court is the validity, under the Batterton test, of the HHS regulations that apply to the 35 SSI states. These states are, by definition, unaffected by the situation in § 209(b) states. Gray Panthers offers guidance and instruction, but has not directly answered the ultimate issue of this case -- the validity of 42 C.F.R. § 435.723.

B. Limited Deeming Is Permissible In SSI States Under the Federal Regulations.

Under the Medicaid statute, as upheld by this Court in Gray Panthers, the Secretary has the power to interpret and

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Footnote 19 continued.

Although plaintiffs had argued below in this case that deeming was not allowed at all in SSI states, they have abandoned that contention and did not raise it as an issue in their petition for writ of certiorari.

define "available" income and resources for making Medicaid determinations. See 42 U.S.C. § 1396a(a)(17)(B). The Secretary has defined "available" in the context of spouses separated by institutionalization differently in the SSI states than in the § 209(b) states:

> "In SSI States, 'deeming' is conducted in the following manner: When the applicant and his spouse live in the same household, the spouse's income and resources always are considered in determining eligibility, 'whether or not they are actually contributed.' 42 C.F.R. § 435.723(b). When the applicant and spouse cease to share the same household, the spouse's income is disregarded the next month, id., § 435.723(d), unless both are eligible for assistance. In the latter case, the income of both is considered for 6 months after their separation. Id., § 435.723(c)." Schweiker v. Gray Panthers, supra, 101 S.Ct., at 2638.

The basic difference between the SSI states' deeming rules and those applicable to § 209(b) states is that the SSI rules

are time limited. Deeming in SSI states is for a "certain period", and can be for a "maximum of six months". McM. Op., 619 F.2d, at 1279 (Pet.App. 38a-39a).

There is no dispute that the deeming regulation "treats the income and resources of an aged, blind or disabled individual under Medicaid in exactly the same manner as SSI, which is the title of the Social Security Act (Title XVI) 'most appropriately applicable' to an aged, blind, or disabled individual." McM. Op., at 1279-1280 (Pet. App. 40a); see Ross Op., 619 F.2d, at 1272-74 (20a-26a).[20/] Thus, the HHS

20/ The difference between the deeming rules authorized by the HHS regulations and those used by Iowa as directed by the district court appears to be twofold. First, Iowa permits deeming without end. Iowa's procedures have no time limits and are applied indefinitely. Second, Iowa's rules would require a different analysis of income during the applicable one-month or six-month period than is employed under the SSI rules.

regulation permits Iowa to employ limited deeming, which is no more, but no less, than that permitted by Congress for SSI.

C. Federal Deeming Regulations For SSI States Are Reasonable.

The crux of the regulation, 42 C.F.R. § 435.723, setting forth Medicaid deeming in Iowa and other SSI states is employment of the SSI deeming rules. It is the controlling factor of the congressionally established link between Medicaid and SSI that mandates the use of these procedures in the SSI states.

Indeed, in explaining the final version of the deeming regulations, the Secretary noted

> "[t]hat the new regulations require states to use Title XVI availability criteria where Medicaid is provided to all supplemental security income recipients, as is already called for in section 1902(a)(10) [42 U.S.C.

§ 1396a(a)(10)(A)] of the Act . . . . [I]f a state covers all individuals eligible for or receiving Title XVI benefits for Medicaid it must apply the Title XVI income and resource eligibility criteria. The states are now specifically required to use the SSI rules on availability of income." 42 Fed.Reg. 2684-85 (1977) (emphasis supplied).

The use of SSI rules stems, as the Secretary recognized, from 42 U.S.C. § 1396a(a)(10)(A) (i.e., the SSI-Medicaid link). The provision states that:

> "A State plan for medical assistance must -- . . . (10) provide -- (A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI . . . or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter . . . ." 42 U.S.C. § 1396a(a)(10)(A).

Under this statute, Congress intended that states provide Medicaid to all "categorically needy" (i.e., those eligible for

or receiving cash assistance).[21/] As recently reiterated by Justice Marshall, "Any state which participates in Medicaid must extend medical benefits to all persons receiving supplemental security income (SSI) benefits . . . . Such persons are known as the 'categorically needy.'" Blum v. Caldwell, 100 S.Ct. 1635, 1636 (Marshall J., in chambers, 1980).

The meaning and import of the SSI-Medicaid link has never been in doubt. Numerous federal courts, including this Court, have acknowledged this link between SSI and Medicaid established in 42 U.S.C. § 1396a(a)(10)(A). See, e.g., Beltran v. Myers, supra, 101 S.Ct., at 1962 n. 3 ("The categorically needy receive Medicaid benefits merely by virtue of their eligibility

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21/ See discussion of "categorically needy" and "medically needy", supra, at 5-9.

for income assistance under the SSI . . . program."); Fabula v. Buck, 598 F.2d 869, 874 n. 13 (4th Cir. 1979) ("[T]he Social Security Act requires that all SSI recipients be included in the state's Medicaid program . . . ."); Friedman v. Berger, 547 F.2d 724, 726 (2d Cir. 1976), cert. denied 430 U.S. 984 (1977) ("Aged, blind, and disabled patients whose personal incomes are low enough to qualify under the SSI program are considered 'categorically needy' and must be included within any state plan, 42 U.S.C. § 1396a(a)(10)(A)."); Manfredi v. Maher, 435 F.Supp. 1106, 1112 (D.Conn. 1977) ("In 35 of the 50 states, . . . Medicaid eligibility is linked directly to the criteria used in determining eligibility for the underlying categorical assistance programs . . . ."); West v. Cole, 390 F.Supp. 91, 98 (N.D.Miss. 1975) ("Congress amended the Medicaid Act at

42 U.S.C. § 1396a(a)(10) to expressly require all states to provide Medicaid assistance to all SSI beneficiaries.")[22/]

Indeed, as this Court pointed out in Gray Panthers, Congress specifically developed the § 209(b) option in order to allow states the opportunity to avoid the SSI-Medicaid link.

> "Congress retained the requirement that all recipients of categorical welfare assistance -- now SSI -- were entitled to Medicaid. Congress feared that these States would withdraw from the cooperative Medicaid program rather than expand their Medicaid coverage in a manner commensurate with the expansion of categorical assistance. '[I]n order not to impose a substantial fiscal burden on these States' or discourgage them from participating, see S.Rep.No. 553, 93d Cong., 1st Sess. 56 (1973), Congress offered what has become known as the '§ 209(b) option.'" 101 S.Ct., at 2637 (footnote omitted).

22/ See also Norman v. St. Clair, supra; Hayes v. Stanton, 512 F.2d 133 (7th Cir. 1975).

Simply stated, 42 U.S.C. § 1396a(a)(10)(A), the SSI-Medicaid link, demands that all categorically needy persons eligible for or receiving SSI also receive Medicaid.[23/] In order for that requirement to be effected when a spouse becomes institutionalized, states such as Iowa, which have voluntarily chosen to use the SSI-Medicaid link, must apply the SSI deeming rules. The Secretary has employed this logic for promulgation of 42 C.F.R.

23/ There is no need for this Court to go beyond consideration of the categorically needy. As previously noted, Iowa has decided not to have a medically needy program. Further, the court of appeals' discussion of the optional categorically needy (the so-called "gap") is likewise irrelevant. The options are by definition, "among the 'categorically needy'". McM. Op., 619 F.2d, at 1284 (Pet.App. 53a). Consequently, their rights to benefits and the rules applicable to them are identical to those of other categorically needy persons. This Court's ruling as to the applicable deeming rules to be applied to the categorically needy will necessarily include all members of the plaintiff class.

§ 435.723.

The SSI deeming rules stem from a number of provisions adopted by Congress in 1972 when it created the SSI program. See 42 U.S.C. §§ 1382(a)(2), (b)(2), 1382c(b), 1382c(f)(1), as added by Pub.L. 92-603, 86 Stat. 1468 (1972).

> "In sum, under the SSI program, deeming is mandated by statute as long as the couple lives together in the same household. If the couple ceases to live together, deeming will cease at the beginning of the month after the month in which they cease to live together if only one spouse is aged, blind or disabled and after six months of separation if both spouses are aged, blind or disabled." McM. Op., 619 F.2d, at 1287 (Pet.App. 61a).

As noted earlier, these rules are identical to the ones adopted by the Secretary in 42 C.F.R. § 435.723 for SSI states like Iowa. "This congruence is not coincidental; it is compelled by the relationship between the SSI and the Medicaid programs." McM.

Op., id., at 1287 (Pet.App. 61a-62a).

The Secretary, then, in defining "availability" in the context of an institutionalized spouse where categorically needy aged, blind, or disabled persons are involved requires use of the same deeming rules as are used in SSI. This choice, although different than the Secretary's choice in § 209(b) states, is reasonable in light of congressionally enacted linkage between SSI and Medicaid voluntarily accepted by Iowa. Without maintaining the SSI deeming rules in § 435.723, an individual could be an SSI recipient but not be eligible for Medicaid. Such a result would be directly contrary to federal law. 42 U.S.C. § 1396a(a)(10)(A).24/

24/ Of course, such a result is a regular occurrence under the Iowa procedures approved by the courts below. For example, if Mrs. Herweg had applied for SSI cash assistance in January, 1977 when she also sought Medicaid benefits,

Only two arguments have been offered which could conceivably support a conclusion, under the Batterton test, that the Secretary's regulation is arbitrary and capricious.[25/] One, based on an

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Footnote 24 continued.

application of the SSI deeming rules would have resulted in her being found eligible for a $25 per month SSI apyment. (This occurs because Mrs. Herweg had been institutionalized for more than one month, and SSI deeming is limited to one month since her spouse is not an SSI "eligible spouse". See McM. Op., 619 F.2d, at 1290-1291 (Pet. App. 69a-72a).) Even though Mrs. Herweg was sufficiently indigent to qualify for receipt of SSI cash benefits, it did not alter Iowa's Medicaid deeming rules. Under those rules, Mrs. Herweg was not automatically eligible for Medicaid and, contrary to the SSI procedures, a significant amount of her husband's income was deemed available to her, despite her indigency.

25/ Since Judge Ross did not analyze the federal regulation under the Batterton standard, plaintiff is forced to consider arguments which might have been pressed using that approach. It is plaintiff's position, of course, that these arguments would not have been sufficient, under Batterton, to support Judge Ross' conclusion.

interpretation of section 1396a(a)(17)(D), suggests that the effect of the Secretary's regulations promulgated under (17)(B) is to nullify paragraph (17)(D). See Ross Op., 619 F.2d, at 1272 (Pet.App. 18a-20a).

This argument, however, is based on a false premise and is contrary to this Court's interpretation of (17)(D) in Gray Panthers. In order to conclude that (D) is nullified, it is necessary to interpret (D) to be mandatory in nature. In other words, only if (D) is seen as requiring spousal deeming in all circumstances does the deeming regulation run contrary to the statutes.

Paragraph (D), however, is not mandatory. It simply permits states to consider the financial responsibility of relatives when the relationship is between spouses or between a parent and a child under 21. See, e.g., Manfredi v. Maher, supra, 435

F.Supp., at 1109. The import of (D), as this Court recognized in Gray Panthers, is that it allows an exception to a policy which otherwise prohibited deeming.

> "It is clear beyond doubt that Congress was wary of imputing the income of others to a Medicaid applicant . . . . Congress treated spouses differently from most other relatives by explicitly authorizing state plans to 'take into account the financial responsibility' of the spouse. 42 U.S.C. § 1396a(a)(17)(D)." Schweiker v. Gray Panthers, supra, 101 S.Ct., at 2642 (footnote ommited).

HHS regulations have not nullified the permissible deeming authorized in (17)(D). On the contrary, consistent with the congressional intent behind (D), the Secretary does permit deeming between spouses in SSI states. The only limitation circumscribed by the regulation is that deeming must be time limited in order to be consistent with Congress' complementary

policy of demanding Medicaid coverage for categorically needy individuals. Rather than act arbitrarily, the Secretary has carefully balanced two congressional directives, as (17)(B) requires, allowing both policies their proper impact.[26/]

The second argument which might be offered to justify a ruling that the HHS

26/ Similarly, it has been suggested that the federal regulations fail because they allow Iowa to enforce spousal responsibility only through its support laws. See Ross Op., 619 F.2d, at 1272 (Pet.App. 18a-19a). However, the HHS regulations do not prohibit all deeming, nor do they leave Iowa's use of spousal responsibility laws as its only recourse. Under the regulations, an SSI state may "enforce spousal financial responsibility through its Medicaid regulations to the extent permissible under the SSI statute", and in addition, enforce greater "financial responsibility . . . through the state's relative responsibility laws." McM. Op., 619 F.2d, at 1280 (Pet.App. 42a) (emphasis in original). Again, this result is consistent with the meaning of (17)(D) and not contrary to congressional intent, as the Secretary has consistently recognized. See 42 Fed.Reg. 2685-2686 (1977).

regulation is improper is that the Secretary has used terminology allegedly contrary to the intent of the "availability" language in (17)(B). Specifically, the criticism focuses on the Secretary's use of the words "actually contributed" rather than "actually available." See Ross Op., 619 F.2d, at 1271-74 (Pet.App. 17a-24a). But this concentration on semantics is a false issue.

The "actually contributed" language has no special significance. It clarifies the intent and meaning of the regulation, but it is not crucial to its effect. The key question is whether any deeming greater than that permitted under SSI will be allowed in SSI states like Iowa. As long as the SSI-Medicaid link is carried forth by adoption of the SSI deeming rules for categorically needy recipients, then the use of a particular word by the Secretary

is irrelevant. The controlling factor which mandates the current regulations and thereby voids Iowa's rules is the relationship between SSI and Medicaid. The use of the word "contributed" is not determinative.[27/]

27/ In addition, it was argued below that the federal regulation fails because it permits, during some periods, unlimited deeming. This is required, however, because SSI allows similar deeming; it must be emphasized, though, that such broad deeming is specifically time limited. Iowa's rules, on the other hand, continue the deeming process indefinitely. The Secretary's decision to choose the time limited SSI approach is consistent with the Secretary's need to develop simple and sound administrative policies.

> "The administration of public assistance based on use of a formula is not inherently arbitrary. Cf. Weinberger v. Salfi, 422 U.S. 749, 781, 782 784, 95 S.Ct. 2457, 2475, 2476, 45 L.Ed.2d 522 (1975) . . . To require individual determinations of need would mandate costly factfinding procedures that would dissipate resources that could have been spent on the needy." Schweiker v. Gray Panthers, supra, 101 S.Ct., at 2642.

Given the strict dictates of the Batterton test, the Secretary's regulations permitting limited deeming under the SSI rules in SSI states like Iowa are fair and reasonable. The regulations define the term "available" as directed by Congress, 42 U.S.C. § 1396a(a)(17)(B), so that it is consistent with the authorization to employ spousal responsibility in (17)(D) as well as with the SSI-Medicaid link, 42 U.S.C. § 1396a(a)(10)(A). Since these regulations are to be given, under Batterton and Gray Panthers, "legislative effect", Iowa's rules, to the extent that they require contrary results, are invalid.

CONCLUSION

The decision of the court of appeals should be reversed.

September, 1981. Respectfully submitted,

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No. 80-60

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

ELVINA M. HERWEG, by her husband and next friend, Darrell E. Herweg; and DARRELL E. HERWEG, on behalf of themselves and all others similarly situated,

Petitioners,

vs.

ROBERT D. RAY, individually and in his capacity as Governor of the State of Iowa; and KEVIN J. BURNS, individually and in his capacity as Commission of the Iowa Department of Social Services,

Respondents.

On Writ of Certiorari to the United States Court of Appeals For The Eighth Circuit

BRIEF FOR RESPONDENTS

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QUESTION PRESENTED

Whether Iowa's traditional exercise of its expressly delegated power to enforce administratively spousal financial responsibility in order to target Medicaid assistance for nursing home care to those most in need may be limited by a one month durational restriction contained in a new regulation promulgated by the Secretary of Health and Human Services.

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No. 80-60

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

ELVINA M. HERWEG, by her husband and next friend, Darrell E. Herweg; and DARRELL E. HERWEG, on behalf of themselves and all others similarly situated,

Petitioners,

vs.

ROBERT D. RAY, individually and in his capacity as Governor of the State of Iowa; and KEVIN J. BURNS, individually and in his capacity as Commission of the Iowa Department of Social Services,

Respondents.

On Writ of Certiorari to the United States Court of Appeals For The Eighth Circuit

BRIEF FOR RESPONDENTS

STATEMENT OF THE CASE

The central issue in this case is whether Iowa's traditional exercise of its expressly delegated power to enforce administratively spousal financial responsibility in order to target Medicaid assistance for nursing home care to those most in need may be limited by a one month durational restriction contained in a new regulation promulgated by the Secretary of Health and Human Services.

In 1965, Congress, recognizing the need to encourage states to provide government sponsored medical assistance as a last

resort to needy persons without other means, passed the Medicaid program. Under Medicaid, states are required to develop plans for providing medical care to the needy consistent with federal statutory requirements. State Medicaid plans are forwarded to the Secretary of Health and Human Services for approval, 42 U.S.C. § 1396a(b). While participation in the program is entirely voluntary, states electing to establish Medicaid programs receive substantial federal financial assistance, 42 U.S.C. § 1396b(a)(1).

Under the statutory provisions of the Medicaid program (which are incorporated into the Social Security Act, Title 42, §§ 1396 *et seq.* of the U.S. Code), state plans are to include "reasonable standards . . . for determining the extent of assistance" under the plan. According to the statutory scheme, these standards may:

> . . . provide for taking into account *only such income and resources, as are, as determined in accordance with standards prescribed by the Secretary, available* to the applicant or recipient, 42 U.S.C. § 1396a(a)(17)(B) (emphasis supplied) (hereinafter referred to as Section 17(B).

The statutory framework further limits state authority to take into account financial responsibility of any individual other than the applicant:

> . . . *unless such applicant or recipient is such individual's spouse* or such individual's child who is under the age of 21 . . . 42 U.S.C. § 1396a(a)(17)(D) (emphasis supplied) (hereinafter referred to as Section 17(D).

The clear import of these Medicaid provisions is that Congress intended to give the states authority to include in their Medicaid plans reasonable standards that allow consideration of the income and resources of an applicant's spouse, provided that the state standards are in turn consistent with standards prescribed by the Secretary.

These statutory directives are drawn into focus when one spouse, institutionalized in a nursing home, applies for Medicaid benefits. The question arises whether and to what extent the income and resources of the noninstitutionalized spouse should be considered available to pay for the cost of nursing home care of the applicant. If some income may be "deemed" available, the state may subtract that amount from the payment it would otherwise make to the vendor of nursing home services under Medicaid.

Over the years, Iowa has exercised the express authority vested in it by Congress in Section 17 by including in its state plan a standard that provided that the income and resources of a noninstitutionalized spouse should be taken into consideration when an applicant spouse is institutionalized. Responsible state officials believed that under local community notions of the nature of marriage obligations prevailing in Iowa, it was reasonable to expect noninstitutionalized spouses to contribute to the cost of care of an institutionalized spouse. Under Iowa's Medicaid standard, Medicaid assistance could be reduced, or even eliminated, depending upon the income and resources of the noninstitutionalized spouse. A generalized formula was used to determine the amount of income of the noninstitutionalized spouse which would be considered available to the institutionalized spouse.[1]

As of 1975, the Secretary's regulation promulgated pursuant to Section 17(B) simply stated "that only such income and resources as are actually available will be considered and that income and resources will be reasonably evaluated," 45 C.F.R. §

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[1] Iowa's formula for computing available income has been frequently amended. The most recent general policy is contained in Social Services Manual Letter No. XII, 1-28 (Part Two), June 3, 1977. *See* Joint Appendix, p. 36. The general policy allowed income of the noninstitutionalized spouse to be deemed available after exclusions for the living expenses of the spouse, for dependent children living at home, for medical expenses, and for earned income.

248.3(b)(1975). The regulation contained no time restriction on state authority to consider spousal financial responsibility.

In December of 1975, however, a decade after Medicaid was established, the Secretary issued a notice of intended action in the Federal Register, 40 Fed. Reg. 60074 (Dec. 31, 1975). In that notice, the Secretary announced the intention of drastically modifying HHS's established approach to Medicaid spousal financial responsibility. Under the proposed regulation, a state plan could generally consider the income and resources of a noninstitutionalized spouse for only one month after separation (six months if the noninstitutionalized spouse is also Medicaid eligible) if the state involved is a so-called SSI state (one in which Medicaid assistance is available to those who qualify for federal Supplemental Security Income benefits). The Secretary apparently belatedly came to the conclusion that this time window was dictated by the Supplemental Security Income amendments to the Social Security Act which were passed more than three years before the notice of intended action.

After the passage of more than two years after the notice, the Secretary in 1977 promulgated the regulation in final form, 42 Fed. Reg. 2684 *et seq.* (Jan. 13, 1977). It states, in relevant part:

> If only one spouse in a couple applies or is eligible and they cease to live together, the agency must consider only the income and resources of the ineligible spouse that are actually contributed to the eligible spouse after the month in which they cease to live together. 42 C.F.R. 435.723(d).

This regulation purports to prevent SSI states from considering the income and resources of a noninstitutionalized spouse beyond one month after separation even if the noninstitutionalized spouse is an extremely wealthy individual.

As an SSI state, Iowa's traditional spousal responsibility policy admittedly did not comport with the Secretary's new regulation because it considered income and resources of a noninstitutionalized spouse beyond the one month limitation in

the regulation. The Iowa General Assembly, determined to maintain the general concept that financially able spouses should be expected to contribute to the cost of institutionalized care before Medicaid payments are made, passed an Act in 1977 which urged the Iowa Department of Social Services to resist federal regulations which "would allow spouse income under certain circumstances to be excluded from the determination of income for intermediate care facility Medicaid eligibility purposes." See H.F. 464, 1977 Iowa Acts, 67th G.A., § 18 (J.A. 48). Director of Social Services Kevin Burns shortly thereafter wrote regional federal officials in Kansas City outlining Iowa's strong opposition to the new federal policy. Among other things, Burns expressed the view that the new federal policy "exceeds the authority provided by the Social Security Act for such regulatory action." (J.A. 52).

Iowa, believing its position most consistent with the Medicaid program and legally defensible, continued to apply its traditional spousal responsibility policy not limited by the time window in the Secretary's regulation. In 1978, the petitioners filed an action in district court challenging Iowa's policy on statutory and constitutional grounds. The parties stipulated (J.A. 76) that the appellants properly represented a class (J.A. 22) consisting of all married couples residing in Iowa in which:

(a) one spouse is eligible for Medicaid and requires institutionalization;

(b) the other spouse is not institutionalized;

(c) the noninstitutionalized spouse has income which is deemed available to the institutionalized spouse.

The petitioners offered four theories attacking Iowa's traditional responsibility policy. First, petitioners contended that Iowa's policy violated the applicable federal regulations. Second, petitioners argued that Iowa's policy violated Section 17 of the Social Security Act. Third, petitioners charged that by

using an "arbitrary formula" to determine the amount of income on the noninsitutionalized spouse, Iowa's policy violated constitutional due process. Finally, the petitioners pleaded that Iowa's policy created two classes of persons, the married and the unmarried, and that the creation of these classes "without sufficient justification" offended equal protection. (J.A. 29-32).[3]

The district court did not directly rule on the constitutional issues. It did hold, however, that Iowa could consider income and resources of a noninstitutionalized spouse provided that the state make an individualized determination of the financial needs of the noninstitutionalized spouse rather than apply a generally applicable formula for determining how much the spouse should be expected to contribute. While the district court did not expressly invalidate the Secretary's new spousal responsibility regulation, the court, by upholding Iowa's authority to apply its spousal responsibility policy in a non time restricted manner, impliedly found the Secretary's regulation unlawful and without effect. See *Herweg* v. *Ray*, 481 F.Supp. 914, 917 (S.D. Iowa 1978).

As a result of the ruling, Iowa reluctantly, but in full compliance with the court's order, altered its spousal responsiblility policy to provide for an individualized determination of the needs of the noninstitutionalized spouse. This new policy was "specifically approved" by the district court in a clarifying order mutually sought by the parties. *Herweg, supra,* 418 F.Supp. at 917.

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[3] The Amicus Brief submitted on behalf of the Grey Panthers suggests that Iowa's policy somehow violates the comparability provisions of the Medicaid act, 42 U.S.C. § 1396a(a)(10), (13), (17). This issue was not litigated below. In any case, Respondents believe that its spousal financial responsibility policy is in full compliance with comparability provisions since it applies to all institutionalized spouses regardless of the SSI category under which they qualify for assistance.

The petitioners appealed to the Eighth Circuit. There, the thrust of their main argument was that "available" income and resources under Section 17(B) included only income that was "actually contributed" by the noninstitutionalized spouse. The petitioners attacked not only the policy of the State of Iowa on this ground, but also the new time restricted financial responsibility regulation promulgated by the Secretary of HHS in 1977. By pressing the claim that only funds "actually contributed" may be considered in making Medicaid determinations, petitioner's argument was strikingly similar to that rejected by this court in *Schweiker* v. *Grey Panthers,* ____ U.S. ____, 101 S.Ct. 2633 (1981). The Eighth Circuit, sitting *en banc,* affirmed the judgment below by an equally divided court, *Herweg* v. *Ray,* 619 F.2d 1265 (8th Cir. 1980).

The two opinions offered by the Eighth Circuit are a study in contrast. Judge Ross wrote that "available" income and resources did not mean income "actually contributed" to the cost of care of the institutionalized spouse. He rested his opinion on the express language of Section 17 of the Social Security Act, which appears to give the states considerable leeway in the crafting of their Medicaid plans, and on the applicable legislative history. Judge Ross rejected the time restricted approach of HHS as inconsistent with the true meaning and intent of Section 17 of the Social Security Act, see *Herweg, supra,* 612 F.2d at 1272-3.

Judge McMillian, on the other hand, believed that whatever the law might have been prior to 1972, the enactment of the Supplemental Security Income Program (SSI) in 1972 significantly altered the legal landscape in the spousal responsibility area. Judge McMillian intricately detailed what he saw as the interrelationship between Medicaid and the SSI program. He observed that prior to the passage of SSI, eligibility for Medicaid was "linked" to eligibility for federal categorical assistance programs. When Congress passed the SSI program, it gave the states the choice of continuing to determine Medicaid

eligibility according to standards then in existence in 1972, or according to the liberalized SSI eligibility requirements. Iowa, Judge McMillian observed, elected to apply the more liberal SSI requirements. Judge McMillian believed that the SSI statute mandated that spousal responsibility be strictly limited to the one and six month time limits embraced by the Secretary's challenged Medicaid regulation. He further reasoned that the method by which a state calculated and enforced its spousal responsibility policy was tantamount to an eligibility requirement. Judge McMillian thus concluded that since Iowa had adopted SSI eligibility standards and SSI has restrictive provisions similar to that embraced in the Secretary's regulation, Iowa's contrary policy must be invalid, *Herweg, supra,* 612 F.2d at 1285-86, 1292.

Petitioners filed for writ of certiorari with this Court. They stated in their petition for certiorari that the question presented was "Whether the Court of Appeals' invalidation of a regulation promulgated by the Department of Health and Human Services which was designed to ensure that, in so-called "SSI states,' Medicaid applicants and recipients would have the eligibility conditions and rules of the Supplemental Security Income ("SSI") program applied to them was appropriate in light of the explicit requirements of the Medicaid and SSI Statutes and the deference due the responsible federal agency."[3]

This Court granted the writ on July 2, 1981.

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[3] Petitioners-Appellants' Brief at 2. Petitioners' decision to support the HHS regulation it attacked in the Court of Appeals below may have been influenced by this Court's decision in *Schweiker* v. *Grey Panthers,* ___ U.S. ___, 101 S.Ct. 2633 (1980).

SUMMARY OF ARGUMENT

1. A federal regulation that attempts to impose a narrow time window on state authority to consider financial responsibility of spouses as expressly authorized in Section 17(D) of the Social Security Act exceeds the Secretary's statutory authority. The time restricted approach is a refusal to promulgate standards of income and resource availability as required by Congress in Section 17(B) of the Act. The legislative history and language of the Medicaid program evince no intent to cut off state authority to consider the financial responsibility of spouses when spouses are not living together due to institutionalization.

2. The so-called "link" between SSI and Medicaid does not support the validity of the Secretary's time limitation. Congress has delegated to the states a more substantial policy role in Medicaid than in the Supplemental Security Income program. Nothing in the express terms of the Supplemental Security Income Act precludes states from considering the financial responsibility of spouses in determining the amount of Medicaid assistance. The SSI requirement that states provide "for making medical assistance available" to SSI recipients is not inconsistent with financial responsibility provisions of Medicaid. All that is required is that medical care be available from some combination of sources that can include government assistance or expected spousal contribution. Nothing in the so-called deeming provisions of the Supplemental Security Act requires restricted Medicaid deeming. By insisting on exercising its expressly delegated statutory power to require reasonable spousal financial responsibility, Iowa does not evade a Congressionally prescribed "choice" between accepting expanded SSI coverage or limiting benefits pursuant to the so-called 209(b) option.

3. The Congressional delegation of power to the states to develop spousal financial responsibility policies, consistent with

valid standards promulgated by the Secretary, rests on sound policy grounds. Reasonable policies of spousal responsibility help states target their Medicaid dollars to those most in need and promotes perceptions of program fairness. Reliance on state responsibility laws is not a meaningful alternative because of the extreme burdens placed on welfare administrators by such a policy.

ARGUMENT

Iowa's present spousal financial responsibility policy is admittedly inconsistent with the new federal regulations. The State allows financial responsibility of spouses to be considered beyond the one month time frame in 42 C.F.R. 435.723(d). At present, each individual is entitled to a determination in which the financial needs of the noninstitutionalized family member are evaluated so that the expectations of support placed upon them are not unreasonable.[4] Given the inconsistency with the federal regulation, Iowa's policy must fall under the Supremacy Clause if the Secretary's regulation is a valid exercise of federal power under Section 17(B) of the Social Security Act, 42 U.S.C. § 1396a(a)(17)(B).

The standard of review of Medicaid regulations promulgated pursuant to 42 U.S.C. § 1369a(a)(17)(B) was discussed in *Schweiker* v. *Grey Panthers*, ____ U.S. ____, 101 S.Ct. 2633 (1981). In that case, the Court made a general observation that the Secretary's definition of the term "available" is entitled to legislative effect. It was observed, however, that the Court must also review regulations to ensure that the Secretary did not "exceed his statutory authority" and that the regulations are not "arbitrary or capricious," 101 S.Ct. at 2640. See also 5 U.S.C. §§ 706(2)A, C. Where the Secretary acts outside the scope of his

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[4] Iowa contends that its present case-by-case policy is not required in light of *Schweiker* v. *Grey Panthers*, ____ U.S. ____. 101 S.Ct. 2633 (1980). That case upheld the application of a a general formula in determining amount of resources "available" to a Medicaid applicant in states exercising the so-called § 209B option. Earlier case law to the contrary is no longer authoritative.

Iowa's experience has not been satisfactory with respect to its present policy. Administrative costs seem to have exceeded the gains of the case by case policy. If Iowa is successful in this litigation, it will give serious consideration to adoption of a reasonable, generally applicable formula for determining spousal financial responsibility of a type sanctioned in *Grey Panthers, supra*, n. 2.

congressionally delegated power, the regulations are not entitled to "legislative effect." When the Secretary acts *ultra vires*, it is the duty of this Court to enforce the statutory mandate of the Congress.

I. A Federal Regulation That Attempts To Impose A Narrow Time Window On State Authority To Consider Financial Responsibility Of Spouses As Expressly Authorized In Section 17(D) Of The Social Security Act Exceeds The Secretary's Statutory Authority.[5]

A. The Secretary's Regulation Attempting To Virtually Eliminate Medicaid Financial Responsibility Of Spouses Separated Due To Institutionalization Is A Refusal To Promulgate Standards As Required By Congress In Section 17(B) Of The Social Security Act.

As indicated above, Section 17(B) allows the states in their Medicaid plans to "provide for taking into account only such income and resources as are, as determined in accordance with

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[5] Petitioners appear to believe that the question of whether the Secretary exceeded her statutory authority was not raised below. Petitioner's Brief at 50, n. 18. This is not correct. While it is true that the phrase "exceeded her statutory authority" does not appear in Respondents' Brief in the Court of Appeals, it is observed that until Congress passes additional legislation, the regulation in question is unlawful. Respondents' Brief at 2. And, respondents stated that federal regulations may not forbid the state from taking into consideration the financial responsibility of an individual dealing with a spouse. Respondents' Brief at 18. The question of whether the Secretary's present regulation was defensible, however, was not the focus of the litigation since the Petitioners, at least in the Court of Appeals, attacked rather than defended the Secretary's regulation. The conflict in the Court of Appeals thus became whether the term "available" in Section 17(B) meant "actually contributed".

If any change has occurred, it is the position of the petitioners. They now in this court seek to defend a regulation of the Secretary which they attacked in the Eighth Circuit.

standards prescribed by the Secretary, available to the applicant or recipient," 42 U.S.C. § 1396a(a)(17)(B), [Emphasis added]. But the Secretary in the instant case has not promulgated "standards" of availability entitled to legislative effect as suggested in the language in *Grey Panthers, supra,* ____ U.S. ____, 101 S.Ct. at 2540. Rather, the Secretary has promulgated an exceedingly stringent time limitation totally absent from the Medicaid statute.[6] Instead of following the Congressional directive to enact standards for the states to follow if they wish to consider the financial responsibility of spouses under the cooperative federalism scheme,[7] the Secretary, without statutory foundation, has simply eliminated off state 17(D) authority except for the very brief one month period.

The scope of the Secretary's authority to establish standards of availability is not particularly difficult to discern. For instance, courts use the term "standard of review" to denote the level of judicial scrutiny to be applied to a specific action generally governmental in nature. Standards of review are sometimes lax, sometimes stringent. But, pursuing the analogy, the cut-off adopted by the Secretary is tantamount to a withdrawal of jurisdiction with no standard of review.[8] It is em-

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[6] Petitioners opines that "Iowa's procedures have no time limits and are applied indefinitely." Petitioners' Brief, p. 55, n. 20. In this respect, Iowa's policy follows the statute, which, unlike the Secretary's regulations, also has no time limits.

[7] As stated in *Norman* v. *St. Clair,* 610 F.2d 1228, 1230 (5th Cir. 1980), *cert. denied sub nom., Schweiker* v. *Norman,* ____ U.S. ____, 101 S.Ct. 3159 (1981), under the plain language of the statute, the states were left to establish and prosecute the responsibility of spouses as a matter of their own discretion. While they might prefer to do this through available statutory and judicial techniquest of forcing one spouse to assume the financial needs of the other, in the context of the Medicaid program they are just as free to do so by regulation.

[8] Consider also the common term "standard of living". A person's standard of living can be high, and it can be low. But there must be some standard, unless death occurs.

phatically not the kind of linedrawing entitled to legislative effect, *Grey Panthers, supra.*

A useful analogy may be found in the Aid to Families with Dependent children cases involving the scope of state authority to establish a "standard of need" in determining who is eligible for public assistance. As this court noted in *Rosado* v. *Wyman,* 397 U.S. 397, 408 (1970), a "standard of need" is "a yardstick for measuring who is eligible for public assistance." In establishing the yardstick, the responsible decisionmaker has "a great deal of discretion". The "standard of need" may or may not include specific items in its calculation. Diversity may exist as to the level of benefits that result. For instance, a standard of need may include a ceiling on the maximum dollars allowable. But, as can readily be seen, *some* yardstick of measurement must be present.

A good example of a specific yardstick, or "standard of need" is contained in the Appendix to this Court's opinion in *Dandridge* v. *Williams,* 397 U.S. 488, 504 (1970). The Appendix presents a matrix used by Maryland authorities in determining the "standard of need" for AFDC applicants. The vertical variable describes the number of persons living in the assistance unit, while the horizontal column presents monthly standards of subsistence needs depending on living circumstances of the applicant.

The matrix in *Dandridge* presents the kind of standard that the Secretary of HHS is required to establish under Section 17(B) of the Act. The Secretary, for instance, may establish an amount of income and resources that must be set aside for the living needs of a noninstitutionalized spouse — in other words, an amount exempt from any state deeming plan. Under such a standard, no income or resources could be deemed available unless the noninstitutionalized spouse had wherewithal that exceeded that amount. The Secretary, in the exercise of sound discretion, can introduce a host of relevant variables that in-

crease or decrease the amount that states could deem available for the cost of care of the institutionalized spouse. But again, at the risk of repetition, *some* yardstick must be available to guide states in the exercise of their expressly delegated authority to provide for spousal financial responsibility under Section 17(B) and (D) of the Act.

The inadequacy of a time restrictive regulation under Section 17(B) is shown by the fact that spousal responsibility does not generally vary over time. Alimony obligations, for instance, can generally be altered after a judgment of divorce only if the comparative financial circumstances of the spouses involved materially change over time. Indeed, in Iowa spousal support has been held to be a continuing obligation, *In re Bagnall's Guardianship,* 29 N.W.2d 597, 614 (Iowa 1947); See § 252A.3, Code of Iowa (1981)

The responsibility of a noninstitutionalized spouse to an institutionalized spouse similarly remains constant, regardless of the length of institutionalization. The Secretary's time restricted approach to financial responsibility is not rationally related to any effectuation of objectives underlying the Medicaid Act. It can hardly be said, for instance, that a one month window allows the states to vindicate their expressly delegated power reasonably to require a spousal financial responsibility in their Medicaid programs, Section 17(D).

The legislative intent behind vesting the Secretary with authority to promulgate *standards* for determining availability of income is not too obscure. As noted in *Norman* v. *St. Clair,* 610 F.2d 1228, 1240 (1980), the enactment of Medicaid was an effort to replace the then existing Kerr-Mills medical assistance program for the aged with an expanded and more effective form of federally assisted state aid to needy individuals. Under the previous Kerr-Mills plans, many states had imposed rigid and complex eligibility standards. At the same time, Congress wish-

ed to leave to the states substantial discretion in operating their programs. The tension between these competing principles is reflected in Sections 17(B) and (D). While Congress in passing Medicaid wished to allow states to continue to have considerable flexibility in the spousal financial responsibility, a mild restraint was included in 17(B). By allowing the Secretary to promulgate general standards of income availability, state discretion could be limited so that the most extreme and perhaps irrational methods of calculating income availability could be avoided.

It is unlikely that Congress would further intrude on state authority to structure spousal financial responsibility without more express action. As this Court has noted, domestic relations has long been regarded as a virtually exclusive province of the states. See *Sosna* v. *Iowa,* 419 U.S. 393, 404 (1970). Congress has also been reluctant to tamper with the state authority in the area. It has not passed, for instance, laws federalizing divorce or substantially describing the incidents of the marriage relationship, but has left such matters to the states. Sections 17(B) and (D) seem to respect that traditional relationship in the context of a federal benefit program.[9]

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[9] Traditionally, welfare programs have looked to responsible family members *first,* before loosening the strings of the public purse. As has been noted by a respected authority, the common law originally had no occassion to concern itself with the duties of support between spouses because of the celebrated doctrine that husband and wife were one in the eyes of the law. Statutory provisions relating to husband and wife evolved in the 19th century. Then, "this family responsibility was primary, i.e. in case of destitution the appropriate family members had to be called upon first. . . ." *See* Riesenfield, *The Formative Era of American Public Assistance Law,* 43 Calif. L. Rev. 176, 199 (1955).

Even unsympathetic commentators have noted that relatives under poor law provisions have been called upon to support family members *before* public aid is given. *See* L. Tully, *Family Responsibility Laws: An Unwise and Unconstitutional Imposition,* 5 Fam. L. J. 32, 32 (1971) ("before public aid is given, or in the case of emergency as soon

In sum, by refusing to establish the parameters of proper state action and instead substituting an irrelevant and deeply intrusive time restriction, the Secretary has exceeded his authority by unlawfully invading the permissible ground of state authority established by Congress under Sections 17(B) and (D).

B. The Legislative History And Language Of Medicaid Evince No Congressional Intent To Cut Off State Authority To Consider Financial Responsibility Of Spouses When Separation Occurs As A Result Of Institutionalization.

As much emphasized by the Petitioners, Congress was "aware of imputing the income of others to a Medicaid applicant." *Grey Panthers*, ___ U.S. ___, 101 S.Ct. at 2642. Nevertheless, it included in the Medicaid statute a specific provision allowing states to consider the income of spouses and parents. Congress apparently believed that these individuals were close enough in consanguinity that states could reasonably require them to contribute to the cost of care of their family.

The legislative history of Medicaid demonstrates that Congress believed it was proper for the states, if they chose, to consider financial responsibility of parents and spouses. As this court already noted, the Senate and House reports endorse this approach. See *Grey Panthers*, ___ U.S. ___, 101 S.Ct. at 2640. In the words of the Senate Report:

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as possible after such aid is given, the relatives shall be called upon [to give aid].") *See also J. ten Broeck, California's Dual System of Family Law: Its Origins, Development, and Present Status*, 17 Stan. L. Rev. 614, 624 (1965)

Upholding the principle of primary family support does not on its face seem to compel administrative enforcement, i.e. limiting welfare checks when responsible family members are present *prior* to resort to judicial enforcement of family responsibility. However, administrative enforcement, as this Court has recognized, is the only practical alternative. *See* discussion under Part III *infra*.

> The Committee believes *it is proper to expect spouses to support each other* and parents to be held accountable for the support of their minor children and their blind or permanently and totally disabled children (emphasis supplied). S.Rep. No. 404, 89th Cong., 1st, 78 (1965); *accord* H.R. Rep. No. 213, 89th Cong., 1st Sess., 68 (1965).

There is simply nothing in the legislative history that suggests that the expectation that spouses and parents may be held responsible for the support of their fellow spouse or minor children is eviscerated when they are no longer living together because of institutionalization.

If anything, the above-cited Senate Report seems to assume that at last parents will continue to be financially responsible for their children who are institutionalized. The Senate Report states that it is "proper" to expect parents "to be held accountable" for the support of children "permanently and totally disabled." Permanently and totally disabled children are very likely to be institutionalized.

Linguistic analysis of other provisions of the Social Security Act reinforces the view that spousal financial responsibility under State Medicaid Plans is not affected by separation. While Section 17(D), which expressly allows states to consider financial responsibility of spouses and parents, contains no limitation with respect to living circumstances, other welfare provisions do contain express restrictions. For instance, at least two provisions relating to Supplemental Security Income benefits expressly are applicable only if spouses live together presently or recently. Specifically:

> For the purposes of this subchapter, the term "eligible spouse" means an aged, blind, or disabled individual who is the husband or wife of another aged, blind, or disabled individual, *and who has not been living apart* from such other aged, blind, or disabled individual *for more than six months,* 42 U.S.C. § 1382c(b) (emphasis supplied).

And, similarly:

> For purpose of determining eligibility for and the amount of benefits for any individual who is married and whose spouse *is living with him* in the same household but is not an eligible spouse, such individual's income and resources shall be deemed to include any income and resources of such spouse, whether or not available to such individual, except to the extent determined by the Secretary to be inequitable under the circumstances, 42 U.S.C. § 1382c(f)(1) (emphasis supplied)

From these provisions, it is obvious that Congress knows full well how to express itself in a fashion which limits the application of a principle to circumstances when spouses live together or have been separated for a specific period of time. No such limitation may be found in Section 17(D). Respondents contend that the Secretary cannot, through regulation, limit the statutory delegation to the states contained in that section[10] without express Congressional authority.

II. The So-Called Link Between SSI And Medicaid Does Not Support The Validity Of The Secretary's Time Limitation.

Much is made by Petitioners of the historical "link" between Medicaid and the Supplemental Security Income schemes. It is said that the SSI statute *requires* that all SSI recipients also *receive* Medicaid assistance without regard to spousal financial responsibility. Specifically, it is claimed that the regulation in question here embraces a "goal of limiting deeming to the same extent that is required in the SSI program."[11] And, it is further claimed that states who wish to restrict their Medicaid financial

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[10] Iowa concedes that Section 17(D) does not *require* interspousal income attribution. *See Herweg* v. *Ray*, 619 F.2d 1265, 1280 (8th Cir. 1980). However, Iowa contends that the statute expressly delegated the *choice* to the states.

[11] *See* Petitioners' Brief at 42.

burdens may become so-called 209b states if they wish.[12] Neither of these contentions, however, form the basis for rewriting Section 17(B) and (D) of the Medicaid program.

A. Congress Has Delegated The States A Far Greater Policy Role In Medicaid Than In The Supplement Security Income Program.

In order to analyze properly the Congressionally intended relationship between the Supplemental Security Income program and Medicaid, it is important to understand the philosophical differences in Congress' approach to the two programs.

SSI is "a national program to provide supplemental security income to individuals who have attained age 65 or are blind or disabled . . .", 42 U.S.C. § 1381. The Program is administered entirely by the federal government, and all the funds come from federal sources. The House Report accompanying the bill creating the SSI program heralds the replacement of "existing Federal-State programs of aid to the aged blind, and permanently and totally disabled" with "a new, totally Federal program." See H. R. Rep. No. 92-231, 92nd Cong., 2nd Sess. (1972) *as reprinted in* 1972 U.S. Code Cong. and Admin. News at 5012.

This centralized federal approach stands in stark contrast with Medicaid. The preamble of Title XIX, which establishes the Medicaid program, states that it was enacted "for the purpose of enabling each state, as far as practical under the conditions in each state," to provide needed medical assistance to its population, 42 U.S.C. § 1396. States are not required to institute a Medicaid program, but if they do, they must develop an elaborate plan for providing medical assistance consistent with federal guidelines, 42 U.S.C. § 1396a. In addition, states

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[12] *Id.*, at 52.

must pay up to 40% of the cost of Medicaid payments, 42 U.S.C. § 1396.[13]

This Court has expressly recognized the state's major role in the Medicaid program. As was stated by this Court in *Beal* v. *Doe,* 432 U.S. 438, 444 (1977), the Medicaid program "confers broad discretion on the States to adopt standards for determining the extent of assistance, requiring only that such standards be 'reasonable' and 'consistent' with the objectives of the Act".

Given the broader responsibilities of the states in fashioning the Medicaid program, and given the expenditure of state dollars that occurs, it seems reasonable the Congress would have intended to provide the states with greater leeway in considering financial responsibility of spouses and parents. It is in large part *their program,* involving *their dollars.*[14]

A Congressional intent to give states breathing room is manifest in Section 17 of the Social Security Act, the key statutory provision in this case. At the risk of repetition, in Section 17, Congress authorized the states to develop Medicaid plans that "include reasonable standards" that:

> (B) provide *for taking into account* only such *income and resources* as are, as determined in accordance with standards prescribed by the secretary, available *to the applicant or recipient* [emphasis supplied] . . . .

And,

> (D) do not take into account the financial responsibility of any individual for any application or recipient of

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[13] *See Friedman* v. *Berger,* 547 F.2d 724, 730 (2nd Cir. 1976) *cert. denied,* 430 U.S. 987 (1977), noting funding difference between Medicaid and SSI.

[14] The wide discretion allowed states under Medicaid has been generally achowledged by the courts. *See Norman* v. *St. Clair, supra,* n. 3, at 1228.

> assistance under the plan *unless such applicant or recipient is such individual's spouse,* or such individual's child who is under the age of 21 [emphasis supplied] . . .

B. Nothing In The Express Terms Of The Supplemental Security Income Act Precludes States From Considering The Financial Responsibility Of Spouses In Determining Whether Medicaid Assistance Is Offered.

Petitioners make the rather sweeping claim that if a person is receiving Supplemental Security Income benefits in an SSI state, they must automatically, in all cases, receive Medicaid benefits, regardless of the financial responsibility of spouses and parents.[11] Authority for this overbroad proposition is said to be rooted in 42 U.S.C. § 1396a(a)(10) which requires state Medicaid plans to provide:

> . . . for making medical assistance *available* to all individuals receiving aid or assistance . . . with respect to whom supplemental security income benefits are paid . . . [emphasis added].

Petitioners appear to argue that this provision requires that all SSI "eligibility" criteria in SSI states superceded the express delegations of authority to the states contained in 17(B) and (D). Operating from this premise, Petitioners then claim that SSI generally limits consideration of financial responsibility of spouses to one month.

1. The SSI Requirement That States Provide "For Making Medical Assistance Available" to SSI Benefit Recipients Is Not Inconsistent With Financial Responsibility Provisions Of Medicaid.

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[11] *See* Petitioners' Brief at 56.

For states which, like Iowa, have elected to be so-called SSI states, 42 U.S.C. § 1396a(a)(10) is applicable. But that provision simply requires that state Medicaid plans provide "for making medical assistance *available*" to individuals receiving SSI benefits. It does not mean that financial responsibility of spouses may not be considered in determining whether or not medical assistance is available. It simply means that for every person receiving SSI assistance, the state plan must show that there is some method for insuring the *availability* of medical care.[16] The source of the funds—whether from Medicaid or from a financially responsible spouse is irrelevant. What is required is that for everyone receiving SSI benefits, the state in its Medicaid plan make some reasonable provision to insure the availability of care to the individual.

Iowa's present policy complies with this statutory mandate. State officials make a determination of the extent to which a spouse or parent can reasonably be expected to contribute to the cost of medical care of the fellow or spouse.[17] Iowa's plan approach thus insures the availability of medical assistance, 42 U.S.C. § 1396a(a)(10) while at the same time giving full effect to

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[16] It is interesting to note that in *Grey Panthers, supra,* n. 3, the Court upheld an approach in which the term "available" did not mean "actually contributed". Similarly, in the context of 42 U.S.C. § 1396(a)(10), the requirement t medical services be "available" under a state Medicaid plan does not mean that the state must actually contribute the funds necessary to pay for the care. Rather, the funds must be available from some combination of sources in the applicant's Medicaid environment.

[17] Iowa's present policy is stated in 770 Iowa Administrative Code §75.4(1)(1981), which states:

> **770-75.5(249A) Computation of countable income and resources for persons in a medical institution.** All income and resources available to an applicant or recipient in a medical institution shall be considered in determining eligibility and financial participation by the resident.

Sections 17(B) and (D) of the Medicaid Act. Respondents submit that its approach harmonizes the statutory provisions involved in the present case far better than the mechanical approach offered by Petitioners.

Put somewhat differently, 42 U.S.C. § 1396a(a)(10) simply means that all recipients of SSI assistance must be *eligible* to receive Medicaid benefits. SSI beneficiaries thus may apply for Medicaid assistance without summary rejection. The second stage in the process, however, is determining the level of state financial participation that must be provided to the applicant to insure the availability of medical assistance of the type and ex-

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75.5(1) The income of the ineligible spouse shall be considered available to the resident in determining eligibility and financial participation. Income shall mean gross income less deductions for social security, federal and state taxes, and other mandatory deductions.

75.5(2)* From the combined income of the resident and ineligible spouse the ineligible spouse may keep funds for the payment of reasonable expenses, subject to verification, which are necessary to maintain the ineligible spouse and dependent children customary standard of living. Payment of old debts is an unreasonable expense that shall be allowed only when the payment is a regular installment payment made pursuant to a legally enforceable contract signed prior to the application for assistance and is a debt upon which the family has been making regular payments.

75.5(3) Resources of the ineligible spouse shall be considered available to the resident in determining eligibility. Exempt and nonexempt resources will be determined in accordance with supplemental security income regulations.

The reasonability of this rule has not been questioned in the litigation. If it is successful in this litigation, however, Iowa may choose to implement a general formula for determining the amount of income available to the institutionalized spouse as expressly sanctioned by this Court in *Grey Panthers, supra.* n. 3.

tent comtemplated under Medicaid.[18] One of the permissible elements in determining the level of state assistance needed to insure the availability of medical care is the financial responsibility of the spouse, limited by proper standards promulgated by the secretary pursuant to Section 17(B).[19]

The above approach is thus entirely consistent with the purpose behind 42 U.S.C. § 1396a(a)(10). This provision was not designed to override state authority to consider financial responsibility of family members in the determination of the level of Medicaid benefits required to insure the availability of medical assistance. Rather, this provision appears crafted to insure that medical assistance is available to *categories* of persons defined as in need of assistance under SSI.[20] In other words, the federal definition of "disabled" or "blind" or "aged" or the income and resources eligibility level would be controlling. Thus, in an SSI state, if the federal government chose to expand

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[18] The difference between eligibility and extent of assistance is recognized in 42 U.S.C. § 1396a(a)(17) which reads in relevant part, "A State plan for medical assistance must . . . include reasonable standards . . . for determining eligibility for *and* the extent of medical assistance under the plan."

[19] Contrary to Judge McMillian's opinion below, Iowa thus has not introduced an additional criterion for Medicaid eligibility. *See Hayes* v. *Stanton*, 512 F.2d 133, 139 (7th Cir. 1975)(distinction between Medicaid coverage and eligibility recognized); *accord, Franssen* v. *Juras*, 406 F.Sup. 1375, 1378 (D. Ore. 1975).

No holding of this Court is to the contrary. The statement contained in the opinion in *Blum* v. *Caldwell*, ____ U.S. ____, 100 S.Ct. 1635, 1636, (Marshall, J., in chambers) (1981), that suggests that SSI eligibles receive Medicaid benefits is dicta. Similarly, observations in *Beltran* v. *Meyers*, ____ U.S. ____, 101 S.Ct. 1961, 1963, n. 1, n. 3 (1981), are only sideline observations and were not directly related to the matters in litigation.

[20] *See West* v. *Cole*, 390 F.Supp. 91, 95 (N.D. Miss. 1975) (discussion of expansion of benefits to disabled minors and raising of income levels). *See* 42 U.S.C. § 138c(a)(3) (extending benefits to disabled of all ages).

the definition of disabled individuals entitled to SSI benefits, the states would be *required* to insure that medical assistance was available to that expanded group of persons.

With respect to income and resources *eligibility* levels, Iowa fully follows the SSI criterion. As SSI eligibility levels for Medicaid assistance are altered by Congress, Iowa follows suit. If the level is increased next year, so too will Iowa's, since it is an SSI state. But Iowa, pursuant to the express delegation in 17(D), maintains that in *calculating* or *determining* whether a person meets that eligibility limit, which admittedly is entirely controlled by SSI standards, it may, if it chooses, reasonably consider spousal financial responsibility, Section 17(D).

Indeed, the distinction between eligibility standards and subsequent application of spousal financial responsibility in determining whether those standards have been met appears to have been recognized by at least one Congressional Committee. The Senate Committee Report considering adoption of the Medicaid Program contains separate subheadings entitled "Eligibility for medical assistance" and "Determination of need for medical assistance". Discussion of spousal financial responsibility falls under the latter heading. See S. Rep. No. 404, 89th Cong., 1st, (1965) *as reprinted in* 1965 U.S. Code Cong. and Admin. News at 2017-18.

Recent legislative action also tends to support proposition that Congress did not intend SSI eligibility requirements to in effect preempt state authority under Medicaid to enforce its notions of proper spousal financial responsibility. Prior to 1980, the circuits split on the question of whether SSI states could establish transfer of asset restrictions on Medicaid receipients not present in the SSI statutes. The Second and Fourth circuits struck down state transfer of asset regulations at least in part on a theory similar to that presented here, namely, that SSI states could not adopt transfer of asset regulations for Medicaid purposes more restrictive than those contained in the SSI program. See

Caldwell v. *Blum*, 621 F.2d 491 (2nd Cir. 1980), *Fabula* v. *Buck*, 598 F.2d 869 (4th Cir. 1979). When the Ninth Circuit came to the opposite conclusion, the Supreme Court granted certiorari to resolve the conflict among the circuits, *Dawson* v. *Meyers*, 622 F.2d 1304 (9th Cir. 1980), *cert. granted sub nom.*, *Beltran* v. *Meyers*, ___ U.S. ___, ___ S.Ct. ___ (1980). Before the Court could decide the question, however, Congress enacted legislation expressly disavowing the restrictive approach utilized by the Second and Fourth Circuits, Pub. L. 96-611, 94 Stat. 3567 (1980). As a result, the court did not need to reach the issue in *Beltran* v. *Meyers*, ___ U.S. ___, 101 S.Ct. 1961 (1981)(judgment vacated and remanded to the Ninth Circuit for consideration in light of the statutory change).

In contrast, a measure that would clearly restrict state spousal responsibility authority along the lines suggested by Petitioners under Medicaid has languished in the Congressional halls. A bill to accomplish this goal was introduced in 1977, but it has not made any progress. S. 1914, 95th Congress, 1st Session. The arguments presented by its sponsor, Senator Birch Bayh, were similar to those outlined in the pre *Grey Panther* court decisions which limited state authority to enforce spousal financial responsibility. See 123 Cong. Rec. S24687 (July 25, 1977).

2. Nothing In The So-Called "Deeming" Provisions Of The Supplemental Security Income Act Requires Time Restricted Medicaid Deeming.

Petitioners claim that SSI provisions require that financial responsibility only be considered for one or six months, depending upon the eligibility status of the non-institutionalized spouse.[21] That is not precise. Rather, the SSI provisions simply do not generally provide express authority for consideration of the financial responsibility of spouses or parents when they are not living with the beneficiary.

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[21] *See* Petitioner's Brief at 62.

For instance, 42 U.S.C. § 1382c(f)(1) provides:

> For purposes of determining eligibility for and the amount of benefits for any individual who is married *and whose spouse is living with him in the same household but is not an eligible spouse,* such individual's income and resources shall be deemed to include any income or resources of such spouse, whether or not available to such individual, except to the extent determined by the Secretary to be inequitable under the circumstances (emphasis supplied).

This provision does not address itself at all to the financial responsibility of spouses not living together. Rather, the provision simply states that where a spouse is living with a noneligible spouse, the applicant spouse's income and resources shall include that of the nonapplicant spouse.[22]

Plainly, this provision does not on its face *proscribe* anything, let alone reasonable state policies enforcing spousal financial responsibility of spouses not living together under Medicaid. Rather, the most that can be said is that this section does not expressly provide statutory authority for broader consideration of spousal financial resources under SSI.[23]

This is not to say that regulations of the Secretary which do not allow consideration of financial responsibility of spouses if the noninstitutionalized spouse is ineligible *under the SSI program* are necessarily unlawful. Conceivably, the Secretary may be correct on the ground that, because the statute does not expressly authorize broader consideration of financial resources,

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[22] *See* dissent of Goodwin, C. J., in *Franssen* v. *Juras,* 406 F.Supp. 1375 (D. Ore. 1975).

[23] Even Judge McMillian, in his opinion in this case which supported HEW, stated that neither the statute nor the legislative history absolutely prohibits "deeming". *See Herweg* v. *Ray,* 619 F.2d 1265, 1279 (8th Cir. 1980).

he is without authority to expand such consideration by rule. But the Medicaid statute *does* contain the express authority which allows states to consider financial responsibility of spouses and parents without any limitation as to living conditions, Section 17(D).

A similar analysis applies to 42 U.S.C. § 1396c(b), which states:

> For the purpose of this subchapter, the term "eligible spouse" means an aged, blind, or disabled individual who is the husband or wife of another aged, blind, or disabled individual *who had not been living apart from such other aged, blind, or disabled individual for more than six months* (emphasis supplied).

This is not really a provision designed to limit financial responsibility of spouses. Indeed, because by definition the other spouse under this statute is eligible for SSI benefits, too, there is no extra money available that might be considered under a state Medicaid plan designed to insure that medical assistance is available.

The purpose of the above provision is plain from the legislative history. It is an antifraud provision. Under the SSI scheme, households who contain two eligible spouses receive *less* assistance than two eligible spouses living separately. The reason for this difference is clear; two persons living together achieve economies of scale and therefore require less assistance than those living separately. Congress feared, however, that couples would temporarily split up in order to receive extra benefits. The six-month requirement was designed to insure that a real breakdown in the family unit occurred before individuals would receive increased benefits. See H.R. Rep. No. 92-231, 92d Cong., 2d Sess. 150 (1971). Because the section has nothing to do with financial responsibility of spouses at all, it is no reed

upon which to override the express terms of Sections 17(B) and (D).[34]

C. By Insisting On Exercising Its Expressly Delegated Statutory Power To Require Reasonable Spousal Financial Responsibility, Iowa Does not Evade A Congressionally Prescribed "Choice" Between Accepting Expanded SSI Coverage Or Limiting Benefits Pursuant To The So-Called 209(b) Option.

The petitioners press the argument that if Iowa wants to enforce administratively spousal responsibility for a period beyond the narrow one-month window imposed by the regulation at issue here, it has the "choice" of becoming a 209(b) state. But this artificially forced "choice" is inconsistent with the federal statutory scheme. Not only is this choice not required, it represents a rewriting of the statutes.

1. Iowa Has Made The Conscious Policy Choice, As Congress Intended, To Accept Liberalized Eligibility Requirements Under The SSI Amendments.

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[34] As the Court of Appeals noted with respect to this provision in *Grey Panthers* v. *Administrator, Health Care Finance,* 629 F.2d 180, 184 (D.C. Cir. 1980), rev'd on other grounds *sub nom., Schweiker* v. *Grey Panthers,* ____ U.S. ____, 101 S.Ct. 2633 (1980), "there is no indication that its propriety (deeming) was considered in the context of separations caused by institutionalization, where fraud is presumably not a concern." *Accord* Comment, *To Deem or Not to Deem: Evaluating and Attributing Available Spousal Income to an Institutionalized Medicaid Applicant,* 67 Va.L.Rev. 767, 779-80 (1980) (Congress established the six month deeming period solely to deter spouses from separating voluntarily in order to obtain higher benefits, a concern that does not exist when institutionalization separates a couple.) *See also* Judge Ross's observations in *Herweg* v. *Ray,* 619 F.2d 1265, 1273, n. 5 (8th Cir. 1980); *Mansfield* v. *Weinberger,* 398 F.Supp. 965, 968-69 (D.D.C. 1975).

After Congress enacted the SSI amendments in 1972, Iowa faced the question of whether to become a so-called 209(b) state, and thereby be able to freeze eligibility requirements to those in force in 1972, 42 U.S.C. § 1396a(f), or accept the liberalized eligibility requirements that necessarily followed if Iowa chose to participate as an SSI state. Responsible officials in Iowa elected the SSI option. Through this decision, Iowa policy-makers recognized the dire need to extend Medical care to disabled minors and to liberalize income and resource limitations on Medicaid eligibility in light of sky-rocketing health care costs and persistent inflation.

In so doing, however, Iowa emphatically did not wish to surrender its authority, expressly delegated to it by Sections 17(B) and 17(D) of the Social Security Act, to consider the income of a noninstitutionalized spouse when calculating whether an institutionalized applicant met the newly liberalized SSI linked income and resource requirements. While Iowa was and is prepared to accept the *substantive* eligibility changes inherent in SSI, it wishes to maintain its Congressionally sanctioned method of determining the income and resources available to an institutionalized spouse. Indeed, Iowa's ability effectively to enforce spousal financial responsibility helps the state limit unnecessary Medicaid expenditures and makes the state more able to meet its expanded burdens as an SSI-Medicaid state.

The relationship between the state's capacity to enforce administratively its policy on spousal financial responsibility and its ability to provide benefits to SSI eligibles was noted in Defendant Burns' communication with HHS officials in 1977 indicating his opposition to HHS's restrictive spousal responsibility regulation. Burns declared that if HHS were to prevail,

> the state may have to revise the state plan and revert to a program which does not accept all SSI eligibles for Medicaid Services [exercise the 209(b) option], thereby reducing the number of persons eligible for medical

assistance and in turn prompt the termination of our contract with the Social Security Administration for determining eligibility for SSI recipients of medical services, actions we do not voluntarily wish to take. Letter, Burns to Davis, June 15, 1977, J. A., p. 50, 53.

As has been recognized by at least one Court of Appeals and not directly challenged by this Court, there is nothing in the legislative history which suggests that the 209(b) was enacted in order to grandfather in deeming practices. See *Grey Panthers* v. *Administrator, Health Care Finance,* 629 F.2d 180, 185 (D.C. Cir. 1980). The converse is also true; there is nothing in the legislative history that suggests that exercise of the so-called 209(b) option was designed to be the only vehicle for preserving state deeming practices.

2. Because Iowa's Spousal Responsibility Policy Applies In Only A Fraction Of Medicaid Cases, Its Enforcement Is Not Tantamount To Exercise Of The 209(b) Option.

As can be seen by the discussion above, Iowa's spousal responsibility policy does not do violence to the substantive eligibility criteria that must be applied in SSI states. Iowa adopts and follows the liberalized standards reflected in the program. Thus, even applying Iowa's deeming policy, there are persons in Iowa who are eligible for Medicaid who would not qualify if Iowa had chosen to become a 209(b) state.

In addition, however, it should be noted that, according to the Secretary, "only seven percent of Medicaid nursing home population have living spouses, many of whom are themselves already receiving assistance, and thus have no 'deemable income'." 42 Fed. Reg. 268 at 2684, at 2685 (Jan. 13, 1977). Thus, Iowa's spousal responsibility policy applies only to a small fraction of Medicaid recipients.

The bottom line is clear: Iowa's policy of spousal responsibility does not transform Iowa into a 209(b) state through the back door. Its policy applies only to a narrow category of Medicaid recipients, and within that category, the liberalized SSI income and resource standards are expressly recognized and given their Congressionally prescribed effect.

III. The Congressional Delegation Of Power To The States To Develop Spousal Financial Responsibility Policies, Consistent With Valid Standards Promulgated By The Secretary, Rests On Sound Policy Grounds.

A. Reasonable Policies Of Spousal Responsibility Help States Target Their Medicaid Dollars To Those Most In Need And Promote Perceptions Of Fair Administration.

It is a political truism today that federal and state governments live in an era of limited resources. Indeed, one of the challenges facing governmental officials is to streamline government welfare programs to provide assistance to those most in need while at the same time efficiently removing the underserving from the welfare rolls.

Reasonable policies of spousal responsibility accomplish this goal. They eliminate the possibility that comparatively wealthy spouses will simply refuse to provide funds for their institutionalized spouse, thereby qualifying the applicant spouse for welfare benefits. As observed by Judge Pell in his dissent in *Brown* v. *Stanton*, a refusal to require spousal responsibility is:

> an open invitation for the spouse to decide that he or she does not wish to make the excess payment. In this era of inflation, and giving consideration to the human inclination not to pay out money when one doesn't have to, I think it reasonable to conclude that few would decline the invitation. 617 F.2d 1224, at 1234 (7th Cir. 1980)

The gutting of administratively enforced spousal financial responsibility as proposed by the Secretary would thus lead to depletion of funds that would otherwise be available to the Medicaid treasury. This depletion would adversely impact efforts to establish satisfactory benefit levels, provide a wide range of service coverage, and maintain relatively liberal eligibility requirements such as those that obtain in SSI states as compared to states who follow the 209(b) option. The result sought by petitioners will thus likely disadvantage those most in need of Medicaid assistance.[11]

In addition to destroying the focus of welfare dollars, elimination of effectively enforced spousal responsibility is highly unfair to those who voluntarily contribute. As was noted in the prevailing opinion below: "A result ousting state authority to require reasonable deeming would be most unfair to the noninstitutionalized spouse who does not contribute what he can to the care of his spouse or to the taxpayers who pay for such care when they are not legally obligated to do so." *Herweg* v. *Ray*, 619 F.2d 1265, 1272 (8th Cir. 1980).

B. Reliance On State Responsibility Laws Is Not A Meaningful Alternative.

It has been suggested that Congress included Section 17(D) in the Medicaid Act Simply to allow states to enforce "relative responsibility laws" against noncontributing spouses. But this Court expressly rejected this approach in *Schweiker* v. *Grey Panthers*. There, the court cited Judge Pell in *Brown* v. *Stanton*, where he noted that it is not:

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[11] However, there is at least one district court case where spousal financial responsibility seems to have been carried to an extreme extent that would evoke pathos in the most hardened state administrator. *See Franssen* v. *Juras*, 406 F.Supp. 1375 (D. Ore. 1975). But such extreme standards may be challenged as unreasonable under 42 U.S.C. § 1396a(a)(17). In addition, the Secretary may promulgate standards limiting the ability of the states to engage in such harsh application of spousal financial responsibility.

> . . . an answer to say that the state can take action against the spouse to recover that which the spouse was legally obligated to pay. (It is) unrealistic to think that the state will engage in a multiplicity of continuing individual lawsuits to recover the money it should not have had to pay out in the first place, 617 F.2d at 1234, cited with approval in *Grey Panthers, supra,* 101 S.Ct. at 2641.

Iowa strongly presses this position before the Court. Lawyers for the Department of Social Services in Iowa are paid their salaries out of the budget of the Department, see § 13.6, Code of Iowa (1981). In order to effectively enforce spousal responsibility laws by filing the multitude of lawsuits, prosecuting them to judgment, and following them through pursuit of creditors remedies if necessary, substantial legal resources would be required.[26] Because the increased legal costs would be drawn from the Social Services budget, fewer dollars would be available for real services.[27]

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[26] Respondents respectfully draw this Court's attention to the uncelebrated Iowa case of *Cherokee County* v. *Smith,* 258 N.W. 182 (Iowa 1935). In this case, Cherokee County sued parents of an adult son under financial responsibility laws to recover a $55 payment by the overseer of the poor. The case resulted in protracted litigation, including an appeal to the state supreme court. The litigative costs far exceeded potential recovery.

While *Cherokee County* obviously represents an extreme example, it graphically illustrates the impracticality of judicial enforcement of family responsibility laws. For a critical discussion of the above case, *see* Tully, *supra,* n. A, at 35-6.

Judicial frustration over inefficiencies in legal enforcement of family responsibility laws is unfortunately illustrated by a case in which a judge is reported to have called all support cases simultaneously and instructed the line up to plead guilty to violations. *See* ten Broeck, *supra,* n. A, at 622-63.

[27] The financial pressures upon Iowa's Medicaid program are growing increasingly severe. Moreover, Congress has reduced Medicaid payments to the states by 3% for fiscal year 1982, 4% for fiscal year 1983, and 4.5% in 1984. *See* the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, Sec. 2161, 95 Stat. 803 (1981). Given the expected

CONCLUSION

The ruling of the United States Court of Appeals for the Eighth Circuit upholding Iowa's Medicaid spousal financial responsibility policy should be affirmed.

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cut in federal dollars, state officials in September, 1981, predicted a Medicaid shortfall of $5,683,000 in program funds and a $150,000 deficit in administration for fiscal year 1982. Department of Social Services, *Overview of Federal Budget Reductions on Department of Social Services,* September 9, 1981, at 14 (simply stating estimates without elaboration).

The notion that family responsibility laws originally evolved as a device to reduce public expenditures appears generally recognized. *See e.g.* M Rosenbaum, *Are Family Responsibility Laws Constitutional,* 1 Fam. L. Q. vol. 4, 55, 56 (1967)

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No. 80-60

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1980

ELVINA M. HERWEG, by her husband and next friend, Darrell E. Herweg; and DARRELL E. HERWEG, on behalf of themselves and all others similarly situated,

Petitioners,

vs.

ROBERT D. RAY, individually and in his capacity as Governor of the State of Iowa; and KEVIN J. BURNS, individually and in his capacity as Commissioner of the Iowa Department of Social Services,

Respondents.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

REPLY BRIEF OF PETITIONERS

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No. 80-60

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On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

---

REPLY BRIEF OF PETITIONERS

I. THE REGULATION AT ISSUE, 42 C.F.R. § 435.723, MUST BE EVALUATED UNDER THE STANDARD OF BATTERTON v. FRANCIS, 432 U.S. 416 (1977).

Although admitting that its rules are "inconsistent with the . . . federal regulations" (Respondents' Brief, at 11), Iowa has attempted to shift the focus of this case toward an evaluation of Iowa's deeming rules and away from the federal regulations. Defendants argue that the state's rules constitute a better interpretation of the federal statutory scheme and that, therefore, despite the conflict with the Secretary, they must be upheld by this court. See Respondents' Brief, at 5.[1/] Iowa, however, has addressed the wrong question.

As both the Brief of Petitioners and

1/ "Iowa . . . believ[es] its position [to be] most consistent with the Medicaid program . . . ." Resp. Br., at 5.

that of the United States have pointed out, the issue for this Court is not the reasonableness of Iowa's rules, but, rather, whether the Secretary's regulations are a proper interpretation of the statute. Congress has delegated to the Secretary, not to the states, the power to enact regulations under 42 U.S.C. § 1396a(a)(17)(B). This Court held that regulations promulgated by the Secretary under this authority are therefore entitled to "legislative effect." Schweiker v. Gray Panthers, 101 S.Ct. 2633, 2640 (1981).

Consequently, the Secretary's regulation, 42 C.F.R. § 435.723, must be upheld, and followed by Iowa, unless the state can demonstrate that the regulation is impermissible under the strict test set forth in Batterton v. Francis, 432 U.S. 416

(1977).[2] The Batterton test does not require this Court to draw fine lines between the views of Iowa and the Secretary regarding congressional directives. On the contrary, Batterton focuses on a much narrower and simpler proposition -- whether the Secretary's interpretation can be viewed to comport with the statute. Id., at 425-426.

Batterton thus acknowledges the modern day congressional need to delegate "legislative" authority to government agencies in order to insure efficient and rational rules for numerous complex federal programs. Without such an option, Congress would be forced to determine on its own the minute details of thousands of federal programs.

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[2] Defendants' inaccurate focus on state rather than federal enactments is highlighted by their failure to discuss or even cite the Batterton case.

This is especially important for the "intricate" Social Security Act, with its "byzantine construction." Schweiker v. Gray Panthers, supra, 101 S.Ct., at 2640. Thus,

> "Congress entrusts to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term. In exercising that responsibility, the Secretary adopts regulations with legislative effect. A reviewing court is not free to set aside those regulations simply because it would have interpreted the statute in a different manner." Batterton v. Francis, supra, 432 U.S., at 425 (emphasis supplied; citation and footnote omitted).

Even if Iowa could do so, it would not be sufficient for it merely to demonstrate the reasonableness of its statutory interpretation. Herweg v. Ray, 619 F.2d 1265, 1277 (8th Cir. 1980) (McM. Op.) That Iowa's interpretation of this federal statute might be reasonable is irrelevant.

Defendants can succeed in this case only if they can overcome the increased burden inherent in attacking federal regulations that have "legislative effect."

In addition to its effort to shift the focus by ignoring the applicable Batterton standards, Iowa has also confused the issues by mischaracterizing the role of the states in the federal Medicaid program. The gist of Iowa's argument is that its actions are imbued with its inherent power as a state, and that power supersedes the power of the Secretary in the Medicaid program.[3/] Medicaid is not, however, simply a state program. It is, as this Court has consistently recognized, a federal-state cooperative program.

3/ See, e.g., Respondents' discussion, at 20-22, with regard to the differences between the SSI and Medicaid programs and the state's role in each of those programs.

Schweiker v. Gray Panthers, supra, 101 S.Ct., at 2636; Harris v. McRae, 448 U.S. 297, 301 (1980).

A federal-state cooperative program is a congressionally enacted system providing federal matching funds as long as states meet federally mandated requirements. Congress provides latitude for the states to structure their programs to suit their individual needs and conditions, but the states are still limited by federal statute and regulations. Schweiker v. Gray Panthers, supra, 101 S.Ct., at 2636; accord, Townsend v. Swank, 404 U.S. 282, 286 (1971).

Of course, states are not required to participate in the Medicaid program. They may also, as petitioners pointed out in their opening brief, at 6-9, accept or reject various options of the federal Medicaid program. But, if a state does

accept the dollars offered by Congress, it "must comply with the requirements imposed both by the Act itself and the Secretary . . . ." Schweiker v. Gray Panthers, supra, 101 S.Ct., at 2636 (emphasis supplied).

If Iowa's analysis of the state's role in Medicaid were upheld by this Court, it would result in chaos for the federal government, the entity that established the program and remains its primary financial supporter. States would then be free, as amicus Gray Panthers has pointed out at 26-27 of its brief, to develop numerous rules and eligibility conditions which are inconsistent between the states, as well as contrary to federal regulations. Rather than hold down costs, as Iowa implies (Respondents' Brief, at 33), such a system would provide no means for the federal government to control its expenditures

under Medicaid.

II. THE SECRETARY'S REGULATIONS ARE REASONABLE IN LIGHT OF THE SSI-MEDICAID LINK AND THE NEED FOR ADMINISTRATIVE EFFICIENCY.

Petitioners, as well as the United States, have closely analyzed the congressional intent underlying the Medicaid program and demonstrated that the Secretary's regulations are reasonable and consistent with that intent. Iowa has offered no new arguments to support its position. Nearly all of their contentions are reflected by Judge Ross in his opinion below and have been thoroughly addressed in the briefs of petitioners and the United States.

Iowa continues to try to sidestep the realities of the SSI-Medicaid link. 42 U.S.C. § 1396a(a)(10). The import of the link, as petitioners and the United States

have emphasized, is that "all recipients of categorical welfare assistance -- now SSI -- were entitled to Medicaid." Schweiker v. Gray Panthers, supra, 101 S.Ct., at 2637; see also Beltran v. Myers, 101 S.Ct. 1961, 1962 n.3 (1981); Beltran v. Myers, supra, 101 S.Ct., at 1963-1964 (Stevens, J., concurring); Blum v. Caldwell, 100 S.Ct. 1635, 1636 (Marshall, J., In Chambers 1980).

Iowa does not deny that the federal regulations effect that requirement, but it points to other congressional action in an attempt to evade the SSI-Medicaid link. Iowa's illustrations, however, support petitioners' position, rather than defendants'. For example, Iowa cites the recent congressional action with regard to Medicaid transfer of assets rules as supporting its position. Pub. L. 96-611, § 5, 94 Stat.

3567 (1980). Respondents' Brief, at 26-27. But that legislation, contrary to Iowa's assertion, reflects the continued congressional policy of requiring those eligible for SSI also to be Medicaid eligible and mandating that Medicaid rules not be more restrictive than those under SSI. Thus, Congress specifically required in that legislation that whatever Medicaid transfer rules are adopted by states, they may not be more restrictive than those established by Congress and the Secretary under SSI. See 42 U.S.C. § 1396a(j)(1), added by Pub. L. 96-611, § 5(b), 94 Stat. 3568 (1980); see also 126 Cong.Rec. S16506 (remarks of Sen. Long, 1980). As a result, no person who transfers assets and remains eligible for SSI will be deprived of Medicaid for

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the same assets transfer.[4/]

The Secretary's interpretation of the deeming rules comports with this congressional philosophy and goal. The deeming rules used in state Medicaid plans cannot result in more restrictive treatment than do the deeming rules used in the SSI program. Iowa's approach has the contrary result; it allows for an SSI recipient to be deprived of Medicaid benefits. Such a result is not only inconsistent with the SSI-Medicaid link, but also violates

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4/ Indeed, even the one exception to this rule, which allows states to employ a longer period of Medicaid ineligibility than SSI ineligibility for transfers of assets worth more than $12,000, 42 U.S.C. § 1396a(j)(2), also supports petitioners. When Congress intends an exception to the general rule requiring no more restrictive Medicaid rules than SSI rules, it explicitly sets out that exception. See also Schweiker v. Gray Panthers, supra, 101 S.Ct., at 2637-2638, discussing the "§ 209(b)" exception to the general rule.

Congress' general policy favoring the interrelationship of Medicaid and SSI.

Iowa has also implied that the SSI-Medicaid link is the only reason to support the Secretary's regulations. Consequently, the state argues that since the Secretary has improperly interpreted the link, there is no further basis for the federal regulations.

Iowa's own statements belie this argument. An important reason for both the SSI and corresponding Medicaid deeming policy is administrative convenience. The Secretary has determined that a simple formula (the one-month and six-month rules) meets the congressional directive and also provides for the necessary simplified and reasonable administration of the program. As this Court observed in Gray Panthers:

> "The administration of public assistance based on the use of

> formula is not inherently arbitrary. Cf. Weinberger v. Salfi, 422 U.S. 749, 781, 782, 784, 95 S.Ct. 2457, 2475, 2476, 45 L.Ed.2d 522 (1975) . . . . To require individual determinations of need would mandate costly fact-finding procedures that would dissipate resources that could have been spent on the needy. Id., at 784, 95 S.Ct., at 2476." Schweiker v. Gray Panthers, supra, 101 S.Ct. at 2642; see also 49 Fed.Reg. 82254, 82257 (1980).5/

Defendants themselves now concede the validity of that position. They note, Resp. Br., at 11 n.4, that the individualized

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5/ The court of Appeals' decision in Gray Panthers, 629 F.2d 180 (D.C. Cir. 1980), required the Secretary to consider specified "relevant factors" in promulgating new deeming regulations for the § 209(b) states. The Secretary did that, and also considered "additional factors", one of which was administrative ease. See 49 Fed. Reg. 82256 (1980). The Secretary decided to use the SSI-type deeming regulations as the most restrictive that a § 209(b) state could employ, noting that that method "advance[s] the statutory goal of simplicity of administration and efficient operation of the Medicaid program." Id., at 82257 (2d col.).

determinations ordered by the district court have resulted in "administrative costs [that] seem to have exceeded the gains of the case-by-case policy".[6/]

The Secretary's rules take that fact into consideration and carefully balance the requirements of SSI and Medicaid congruence with the need for administrative

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6/ Iowa is apparently considering using these additional administrative costs as a reason for ignoring the lower court's order. The state contends that because, in its view, Gray Panthers does not mandate individual dterminations, it can change its rules despite the failure to appeal the district court's order. Resp. Br., at 11 n.4. But that option is not available to the state.

This court recently reiterated that the failure to appeal a decision binds the losing party, regardless of later decisions of higher courts in other cases on the same or similar issues. Federated Dept. Stores, Inc. v. Moitie, 101 S.Ct. 2424, 2427 (1981). Iowa's failure to appeal the district court directive has rendered that holding res judicata; subsequent legal analysis does not provide a basis for violating the district court's directives.

simplification. These rules provide a reasonable balance between administrative need and congressional directive and are not, under the Batterton-Gray Panthers analysis, arbitrary, capricious or beyond the authority granted the Secretary.

CONCLUSION

For the reasons set out in this and in Petitioners' opening brief, the decision of the Court of Appeals should be reversed.

December, 1981.

Respectfully submitted,

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No. 80-60

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1980

ELVINA HERWEG, et al.,

Petitioners

vs.

ROBERT D. RAY, et al.,

Respondents.

BRIEF AMICUS CURIAE ON BEHALF OF THE GRAY PANTHERS

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Respondents.

BRIEF AMICUS CURIAE ON BEHALF OF THE GRAY PANTHERS

INTEREST OF AMICUS CURIAE

The Gray Panthers are an unincorporated national organization whose members are concerned about the quality of life of older Americans. To that end, the Gray Panthers engage in extensive litigative and legislative advocacy on behalf

of elderly persons throughout the country. See Schweiker v. Gray Panthers, ___ U.S. ___, 101 S.Ct. 2633, 2638 (1981).

Many members of the Gray Panthers are Medicaid recipients, and as a result, the organization is committed to ensuring that states administer their Medicaid programs in a manner which conforms to federal requirements. Ibid.

Medicaid benefits are of crucial importance to low-income elderly persons who receive nursing home care on an ongoing and uninterrupted basis. Without nursing home care, some will die and others will require frequent and prolonged hospitalizations.

This case concerns the state of Iowa's rather unique Medicaid deeming policies between a spouse who is in an institution and a spouse and children living at home. Iowa's deeming policies are unusual as discussed below at pp. 13, 14 and 16 because they differe significantly from the

Medicaid deeming policies in the thirty-three other "SSI states" and the fifteen other "209(b) states." As a result of the application of these policies, Petitioner Ms. Elvina Herweg was at one point wholly denied Medicaid eligibility for nursing home care. Herweg v. Ray, 619 F.2d 1265, 1268 (8th Cir., 1980). These deeming policies would have then left Mr. Darrell Herweg and his three daughters with a debt of $300 each month after meeting the costs of Ms. Herweg's nursing home care and before meeting any of their own subsistence needs. Ibid at 1268.

Amicus is gravely concerned about the adverse impact which the decision of the United States Court of Appeals in the present case will have on Medicaid recipients who are members of the Gray Panthers. Elderly recipients, some of whom are in nursing homes, and some whose spouses are in nursing homes are affected by the deeming policies at issue in this case.

Some may lose Medicaid eligibility depending on the results of this case. Others may be forced to live at greatly reduced subsistence standards.

The split decision of the Court of Appeals in the case at bar affects not only elderly Medicaid recipients in Iowa. The decision by this Court could affect elderly Medicaid recipients in thirty-three other states which currently follow the deeming policies applicable to the Supplemental Security Income Program (SSI).

Because of the importance of this case, the Gray Panthers present herewith a brief containing an examination of the critical federal Statutory policies at issue. This brief addresses in turn (1) the fundamental Medicaid requirement that the states cover all categorically needy public assistance recipients, (2) the basic equity requirements of the Medicaid statute mandating that states evaluate income, need, and resources in a comparable fashion for all indigent persons

covered by the Medicaid programs and (3) the impact of a decision in this case on Medicaid beneficiaries in the thrity-three other states which extend Medicaid coverage to all SSI beneficiaries (the SSI states).

Amicus is represented by counsel who specialize in health law in general, and Medicaid law in particular.

Most importantly, amicus brings to this Court a national perspective on a case of great magnitude for millions of Medicaid beneficiaries throughout the country.

ARGUMENT

I

IOWA'S DEEMING POLICIES VIOLATE CONGRESS' FUNDAMENTAL GUARANTEE OF MEDICAID COVERAGE FOR CATEGORICALLY NEEDY PUBLIC ASSISTANCE RECIPIENTS

When Congress established the Medicaid program in 1965, it required states that wished

to receive federal matching funds to meet certain federal minimum requirements. At the same time, Congress also set the maximum parameters for which a state can receive federal matching funds to provide health care to the indigents. The irreducible or basic minimum which all states had to provide to qualify for federal Medicaid funds were the five basic mandatory services for all federal public assistance recipients under the Old Age Assistance, Aid to the Permanently and Totally Disabled, Aid to the Blind and Aid to Families with Dependent Children programs. 42 U.S.C. §1396a(a)(10)(a) and (13)(B). These mandatory eligibles are hereinafter referred to as the categorically needy.[1/] Congress gave the

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1/ Conress gave states the option to provide Medicaid coverage to persons with incomes and resources equal to or lower than the federal public assistance levels, who were categorically linked to the federal public assistance programs but who for one reason or another were not actually receiving public assistance. 42 C.F.R. 435.200-.231. These are referred to as the categorically needy options. The

(cont.)

states the option to cover categorically linked individuals who had incomes and resources somewhat above the federal public assistance levels but whose incomes were inadequate to secure needed medical care. 42 U.S.C. §1396a(a)(10)(C). This group is referred to as the medically needy and is covered by 30 states but not Iowa. Congress further gave states the option

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1/ (cont.)

categorically needy options include a number of different sub-groups, and states may choose which of the subgroups to cover. The subgroups include: persons who would be eligible for AFDC or SSI but have chosen not to apply; persons who would be eligible for AFDC or SSI but for their residence in a nursing home or other institution; recipients of optional state supplementation to SSI payments, children in foster care, subsidized adoptive homes, unemployed families, and intact families; unborn children; persons in nursing homes whos gross incomes are less thatn 300% of the SSI need level. 42 C.F.R. 435.200-.231. Iowa's selection of subgroups appears at CCH Medicare-Medicaid Guide §15,586. Iowa's choices include the following subroups for which Ms. Herweg is eligible but for Iowa's deeming policy: persons who would be eligible for SSI but for their residence in a nursing home or other institution, and persons in institutions whose gross income is less than 300% of the SSI needs level. 42 C.F.R. 435.211, and .231.

to cover 12 optional services for the categorically needy and medically needy. 42 U.S.C. §1396a (a)(13), and 1396d(a)(6-17). Within these maximum and minimums, states had flexibility to design their Medicaid programs to best meet the availability of revenues and the health needs of the poor.[2/]

From the inception of the Medicaid program to the present, the requirement to cover the categorically needy[3/] has been the foremost concern of Congress:

2/ States who chose to participate in the program were required to make progress from the basic minimum of the mandatory services to the categorically needy towards and to achieve by 1975 comprehensive coverage of all optional eligibles and optional services. 42 U.S.C. 1396a(d), repealed by §231 of the Social Security Amendments of 1972, P.L. 91-603.

3/ Congress' particular concern to ensure Medicaid coverage for the categorically needy was firmly historically rooted. From 1935 to the present, Congress had either set or was thoroughly familiar with the categorical eligibility requirements, the need levels, income disregards and

(cont.)

> Under the committee bill, a State plan to be approved must include provision for medical assistance for all individuals receiving aid or assistance under State plans approved under titles I, IV, X, XIV, and XVI. It is only if this group is provided for that States may include medical assistance to the less needy. H. Rep. No. 213, 89th Cong. 1st Sess., 1965 U.S. Code Cong. and Admin. News p. 2017.

3/ (cont.)

resource standards required by Congress and used by the states. See 42 U.S.C. §301 et seq.; §1201 et seq. and §1351 et seq. With some variation, Congress simply transposed these familiar eligibility requirements into the Medicaid program. See 42 U.S.C. §1396a(a)(17); H. Rep. 89-213, 1965 U.S. Code of Cong. and Ad. News pp. 2017-18. The historical consensus that the aged, blind, disabled and children receiving public assistance were the deserving poor, the neediest of the needy, who had no other recourse to secure medical care was certainly a contributing factor in Congress' decision. See pp. 9-12 supra. Moreover, since all states already had the federal public assistance programs, and since many already paid for some medical care to the categorically needy aged under the Kerr-Mills program and paid for some medical care to the categorically needy families, and blind and disabled individuals through vendor payments, Congress made an easy-to-understand offer to states: the federal government would match from 50 to 83% of the costs of a basic package of medical services to the same group of eligibles for whom the federal and state governments already were making subsistence payments on a matching basis. H. Rep. 89-213, supra.

In 1967, Congress, disturbed at the growth of some states' expenditures for the medically needy which it believed were imperiling coverage for the categorically needy public assistance recipients, set a cap on states' medically needy need levels. See 42 U.S.C. § 1396b(f) 42 C.F.R. 435.1007. The Senate Report review the problem as follows:

> The tendency of some States to identify as eligible for medical assistance under title XIX large numbers of persons who could reasonably be expected to pay some, or all, of their medical expenses . . . has developed future cost projections of a level totally inconsistent with the expectations of the Congress when it enacted itile XIX in 1965. . ..
>
> Under the committee bill, the full Federal medical assistane percentage would continue to be available for medical assistance granted to those persons most in need. . .
>
> 1. Cash assistance recipients;
> 2. Persons eligible for cash except that they do not meet durational residence requirements;
> 3. Children under 21 eligible for AFDC except for age or school attendance requirements; and
> 4. Individuals in medical

> institutions who would qualify for cash assistance if they lived outside of the institutions. . . .
>
> However, with respect to the medically indigent -- those whose income is too high for them to be characterized by a State as in need of welfare -- there would be substantial cutbacks in Federal matching funds S. Rep. No. 744, 90th Cong., 1st Sess., 1967 U.S. Code of Cong., and Ad. News 3012-14. (Emphasis added.)

Thus in 1967, Congress, facing its initial Medicaid funding crisis, reaffirmed its intent to ensure complete Medicaid coverage for the categorically needy and the categorically needy options. Ibid; see also 1967 U.S. Code of Cong. and Admin. News 3020.[4/]

4/ In rejecting proposals to impose copayments on the categorically needy, the Senate said: "It would not be appropriate to impose such charges upon cash assistance recipients because such persons have been determined to have no income or resources available to meet such charges." Ibid; 1967 U.S. Code of Cong. & Admin. News at 3024.

Two years later, Medicaid's fundamental guarantee to the categorically needy was reiterated when Congress, this time responding to state cries of fiscal distress, extended the time period for the states to make progress towards a comprehensive program of all eligibles and all services. See P. L. 91-56 §2d; the Social Security Amendments of 1969.

> The committee wants to make it clear that its amendment in nowise affects the obligation of a State to provide at least the five basic services now required under present law for cash assistance recipients. S. Rep. 91-222, 91st Congressional and Administrative News 1079.

In 1972, Congress passed the SSI program which consolidated the public assistance programs for the aged, blind, and disabled into a single national program. See 42 U.S.C. 1381 et seq. In that context Congress amended the Medicaid statute to require states to provide categorically needy Medicaid coverage for SSI eligibles. See P. L. 93-233 §13(a)(3) codified at 42 U.S.C.

§1396a(a)(10)(a). The only exception permitted to full Medicaid coverage of the SSI eligibles was for those states which selected the "209(b)" option of covering all the SSI-linked needy on a spend down basis.[5/]

SSI was to be financed exclusively through federal dollars; the need levels, income disregards, and resource standards would be established by Congress and the Department of Health and Human Services (HHS); the standards would be uniform, and they would be uniformly administered by HHS throughout the country. Schweiker v. Gray Panthers, 101 S.Ct. 2633, 2637. While SSI would extinguish states' future obligation to pay for the subsistence needs of the aged, blind, and disabled, some states feared that the eligibility improvements mandated by the new SSI standards would balloon their numbers of categorically

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5/ Section 209(b) of the Social Security Amendments of 1972 is codified at 42 U.S.C. §1396a(f).

needy Medically eligibles.[6/] Ibid; See S. Rep. 553, 93rd Cong., 1st Sess., 56, 1973 U.S. Code of Cong. and Admin News p. 1383-4. These state fears persuaded Congress to enact the 209(b) Medicaid need levels and resource standards disability criteria and income disregards in determining Medicaid eligibility for the SSI categorically needy and the SSI linked medically needy. However, to protect the integrity of 1396a(a)(10)(a)'s commitment to cover the categorically needy, a state choosing the 209(b) option (1) is required to allow SSI eligibles and all other SSI-linked persons to "spend down,"[7/] and (2) is mandated to disregard all SSI income in determining Medicaid

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6/ Due to the federal comparability requirements discussed subsequently, the improvements in SSI and thus Medicaid categorically needly eligibility would also be mandated for the SSI linked medically needy. See 42 U.S.C. §1396a(a)(17); 42 C.F.R. 435.812, .822, .831, and .840.

7/ Spend down allows a person with income above the state's need levels to achieve Medicaid

(cont.)

eligibility criteria more restrictively than it did for categorically needy public assistance recipients on January 1, 1972. 42 U.S.C. §1369a(f); 42 C.F.R. 435.731 and .732.

Iowa has not chosen the 209(b) option and does not permit persons eligible as categorically needy or as categorically needy options to spend down. If it had, Ms. Herweg would be able to spend down and become Medicaid eligible. See Herweg v. Ray, 619 F.2d 1265, 1290-1 (8th Cir. 1980).

Iowa is an SSI state and has agreed to accept the SSI need levels, SSI resource standards, SSI income and disregards, and SSI disability criteria. Ms. Herweg's income and resources are such that

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7/ (cont.)

eligibility once his incurred medical expenses reduce his income to the state's need level. Spend down is always a requirement in the medically needy program; however, in 209(b) states, the categorically needy options, and the medically needy who are SSI-linked must all be permitted to spend down. 42 C.F.R. 435.732, and .831.

she would qualify for SSI and is thus categorically needy. Ibid at 1291-2. Iowa's failure to provide Medicaid coverage for a categorically needy eligible due to its unique deeming policy violates 42 U.S.C. §1396a(a)(10)(a)'s historic guarantee of Medicaid coverage for persons eligible for the federal public assistance categories.

II

IOWA'S DEEMING POLICY VIOLATES THE MEDICAID COMPARABILITY STATUTE

When Congress adopted the Medicaid program, one of its prime concerns was to ensure a substantial measure of intra-state equity. By equity, amicus refers to the concept both in social welfare policy and in law that persons in similar circumstances should be afforded similar treatment, and that persons in identical circumstances should be afforded identical treatment.

Under Kerr-Mills and the public assistance vendor payment programs which preceded Medicaid, eligibility factors and the scope of services varied widely among the aged, blind, disabled, and families. Congress determined that Medicaid eligibility and services would be provided on a comparable and equitable basis between and among the categorically needy public assistance categories, as well as between the categorically and medically needy. This was codified in 42 U.S.C. §1396a(a)(10), (13), and (17).

The comments of the House Committee Report are most instructive:

> This will assure comparable treatment for all of the needy aided under the federally aided categories of assistance . . . .
>
> This was included in order to make sure that the most needy in a State receive no less comprehensive care than those who are not as needy. . . .
>
> Thus, the income and resources limitation for the aged must be comparable to that set for the disabled and blind and must also have a comparability for

that set for families with children who, except for their income and resources, would be eligible for AFDC.

Although States may set a limitation on income and resources which individuals may hold and be eligible for aid, they must do so by maintaining comparability among the various categorical groups of needy people. Whatever level of financial eligibility the State determines to be that which is applicable for the eligibility of the needy aged, for example, shall be comparable to that which the State sets to determine the eligibility for the needy blind and disabled; and must also have comparability to the standards used to determine the eligibility of those who are to receive medical assistance as needy children and the parents or other relatives caring for them. H. Rep. 89-213, 1965 U.S. Code of Cong. and Admin. News 2017-18.[8/]

8/ Since 1965, Congress has made only two exceptions to comparability. In 1967, Congress allowed states to provide more comprehensive coverage to the aged whom the state bought in to Medicare Part B and allowed the states to provide the medically needy with a different basic package of 7 out of the 17 Medicaid services so long as the package did not exceed the services offered to the categorically needy. See 42 U.S.C. §1396a(a)(10)(c) and (13)(C); S. Rep. No. 744, 90th Cong., 1st Sess., 1967 U.S. Code of Cong. and Admin. News 3019-20.

(cont.)

HHS (then HEW) implemented the federal comparability mandates by a straight-forward set of regulations. In SSI states, the eligibility for the categorically needy options must be assessed under the same need levels, income disregards, and resource standards as the categorically needy to whom they are linked. 42 C.F.R. 435.711 et seq. Financial eligibility for SSI recipients and for SSI linked categorically needy options are determined identically to each other. 42 C.F.R.

8/ (cont.)

In 1981, Congress allowed states to redesign their medically needy programs by repealing some of the comparability limitations on selection of services for the medically needy codified at 42 U.S.C. §1396a(10)(c). This change is not relevant to this case because Iowa has no medically needy program. However, the language of the conference committee report shows the continuing concerns of both the House and the Senate that eligibility be determined comparably. "Moreover it is not the intent of the Conference to alter the requirements under 1902 (a)(17) of the Social Security Act relating to comparable treatment of income and resources between categorically and medically needy programs." 1981 Congressional Record H-5804, H-5813 (Reps. Waxman and Dingell) (July 31, 1981).

435.721-.725. Financial eligibility for medically needy SSI-linked recipients are determined under need levels, income disregards, and resource standards which are either identical to or more liberal than those used in determining eligibility for the SSI and AFDC categorically needy. 42 C.F.R. 435.812, .822, .831 and .840.

The comparability provisions governing the 209(b) states eligibility standards are the same. Eligibility for the aged, blind and disabled categorically needy options must be assessed under the same need levels, disregards, and resource standards as the categorically needy aged, blind and disabled. 42 C.F.R. 435.731-.734. In 209(b) states, financial eligibility for medically needy aged, blind and disabled recipients must be determined under need levels, income disregards, and resource standards which are identical to or more liberal than the most liberal standards used in determining Medicaid eligibility for the aged,

blind, and disabled categorically needy or the 1972 standard whichever is higher. 42 C.F.R. 435.812(c), .831(a)(3), and .840(b).

Iowa's deeming policy violates the federal comparability requirements because it uses a different deeming policy for the categorically needy to whom they are linked. No other SSI or 209(b) state has adopted such a policy; it is both clearly inequitable and a violation of comparability. See 42 U.S.C. §1396a(a)(17) and 42 C.F.R. 435.721 and .723(d).

For Iowa to make Ms. Herweg's eligibility dependent on whether she applies at the Social Security Administration office or the local welfare office is to set at naught the comparability principle which was and is at the heart of the enactment and administration of the Medicaid program.

III

CONCLUSION

The crux of the dispute between Ms. Herweg and the state of Iowa is that Iowa asserts it is free to apply a more restrictive income disregard under its deeming rules than is permitted for "SSI states" under the Medicaid program. Under the SSI program and under the Medicaid program in "SSI states," income may be deemed from a spouse at home to a spouse in an institution for one month only. 42 U.S.C. §1382c(f)(1); 20 C.F.R. 416.1185(e)(1); 42 C.F.R. 435.723(d). After one month, the income must be disregarded. Ibid. This is referred to as time restricted deeming. Under Iowa's Medicaid plan, income may be deemed from a spouse at home to a spouse in an institution without any time restrictions. Under this court's ruling in Schweiker v. Gray Panthers, 101 S.Ct. 2635 (1981), Iowa can lawfully deem this income

without time restrictions, if it chooses a 209(b) state.[9/] This it has not chosen to do. It has chosen instead to set its policy at variance not only with the Medicaid and SSI deeming rules but also at variance with every other "SSI state." The Iowa legislature and Department of Social Services apparently have a profound philosophical disagreement with the deeming policies set forth in the SSI statute and regulations. A state which disagrees can decide, as fifteen other states have, to select the 209(b) option, or it can even decide not to participate in Medicaid. Schweiker v. Gray Panthers, 101 S.Ct. 2837-8. This case presents critical equity problems of inter-state variation; Iowa will not conform to the Medicaid-SSI policies of thirty-three of the thirty-four "SSI states," nor will it conform to the Medicaid spend down policies

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9/ If Iowa chose the 209(b) option and imposed deeming which is not time restricted, Ms. Herweg would be able to spend down and become Medicaid eligible. Herweg v. Ray, 619 F.2d 1290-1.

of fifteen other "209(b)" states.

Iowa has signed a "1634 agreement" under which the federal government pays for and does the administrative task of determining both SSI and Medicaid eligibility, then by computer tape it certifies the individual to the state as Medicaid eligible. See 42 U.S.C. §1383c; 20 C.F.R. 416.2101-.2119. In return, Iowa agrees to accept the SSI policies and the SSA determination of Medicaid eligibility. Ibid. Since Ms. Herweg has no income and since the SSI deeming disregard is time limited if she applied for SSI, she would be eligible and would receive a $25 monthly personal needs allowance. Herweg v. Ray, 619 F.2d 1290-1. She would also be certified to the state as Medicaid eligible and would receive her regular monthly Medicaid card. Because of its 1634 agreement, Iowa does not conduct an independent determination of Medicaid eligibility, and apply its own deeming rules to the categorically needy SSI recipients.

Because Ms. Herweg either did not want or was unaware of her eligibility for the SSI personal needs allowance, she applied to the Iowa Medicaid program as one who would be eligible but for her institutional status.[10/] Because Ms. Herweg applied to the Iowa Medicaid program directly, they determined her eligibility pursuant to the Iowa deeming rules and ultimately disqualified her from Medicaid. Ms. Herweg is in the anomalous position of being Medicaid eligible in Iowa if she applies for SSI and Medicaid at the United States Social Security Administration Office, but ineligible for Medicaid if she applies at the Iowa Welfare Department office. She will be eligible for Medicaid if she applies for public assistance and is categorically needy. In Iowa and only in Iowa, she will be ineligible for Medicaid if she does not apply for

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10/ See 42 U.S.C. §1396a(a)(10)(11); 42 C.F.R. 435.211 and .231. These are categorically needy options covered by the state of Iowa. CCH Medicare-Medicaid Guide §15,586 (Iowa State Plan).

public assistance and instead applies under a categorically needy option. As has been discussed this is precisely the sort of intra-state equity problem which Congress prohibited by requiring comparability in the eligibility determinations for the categorically needy. The categorically needy options and the medically needy.

If the state of Iowa can establish a Medicaid deeming policy for the categorically needy at odds with the Medicaid and SSI deeming policy for the categorically needy, other states will consider themselves equally free to balkanize their policies. A "SSI state" such as Alabama might want to set a lower Medicaid needs standard than the SSI need standard. Texas might prefer a Medicaid disability standard more stringent htan the SSI disability standard. Wyoming might prefer a more restrictive resource standard. The aged, blind and disabled public assistance recipients in receipt of SSI in those "SSI states" would then be cut off

Medicaid and denied even the opportunity to "spend down" to Medicaid eligibility which is guaranteed in 209(b) states. At that point the federal Medicaid program's historic guarantee of Medicaid eligibility for the mandatory services for the categorically needy is eroded beyond recognition. States can and will begin to pick and choose which of the SSI recipients they deem least truly needy and adopt policies which terminate their eligibility. HHS will be unable to monitor, let along regulate and control states' endless permutations on income, resource, and need requirements, and the program will have lost any semblance of the Congressional intent to create a basic minimum level of eligibility and services to the poorest of the poor in this nation.

For all reasons discussed above, amicus urges this Court to find for the appellant Ms. Herweg, to reverse the decision of the District Court and the split decision of the Circuit Court

of Appeals, and to order Appellee Iowa Department of Social Services to conform its deeming policies to the federal regulations on point. 42 C.F.R. 435.723.

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No. 80-60

In the Supreme Court of the United States

OCTOBER TERM, 1980

ELVINA M. HERWEG, ET AL., PETITIONERS

v.

ROBERT L. RAY, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether regulations of the Secretary of Health and Human Services limiting the extent to which certain states that participate in the Medicaid program may consider the income of an applicant's spouse in determining eligibility for and the amount of Medicaid assistance are arbitrary, capricious, or otherwise unlawful.

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In the Supreme Court of the United States

OCTOBER TERM, 1980

No. 80-60

ELVINA M. HERWEG, ET AL., PETITIONERS

v.

ROBERT D. RAY, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

INTEREST OF THE UNITED STATES

In fiscal year 1977, more than 23 million individuals received federal and state Medicaid assistance totalling more than $16 billion. Medicaid/Medicare Management Institute, *Data on the Medicaid Program: Eligibility, Services, Expenditures* 40, 57 (rev. ed. 1979). The Secretary of Health and Human Services is responsible for requiring states that participate in the Medicaid program to provide medical assistance to each qualified applicant with a minimum of administrative delay and cost and to assure that participating states do not receive federal financial assistance for providing medical assistance to any applicant who is not among the intended beneficiaries of the Medicaid program. Consistent with

these responsibilities, the Secretary has issued regulations prescribing standards for determining the amount of income that is "available" (42 U.S.C. 1396a(a)(17)(B)) to Medicaid applicants. 42 C.F.R. 435.723, 435.700. The judgment of the district court, affirmed by an equally divided court of appeals, effectively requires the State of Iowa to consider income as "available" to certain Medicaid applicants without regard to the limitations imposed by the Secretary's regulations and, therefore, threatens to result in the denial of benefits to qualified applicants.

STATEMENT

1. The Medicaid program was established in Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae*, 448 U.S. 297, 301 (1980); see *Schweiker* v. *Gray Panthers*, No. 80-756 (June 25, 1981), slip op. 1. As adopted in 1965, Title XIX only required participating states to provide medical assistance to individuals who received cash assistance under one of the four "categorically needy" assistance programs established in the Social Security Act.[1] 42 U.S.C. (1970 ed.) 1396a(a)(10); see *Schweiker* v. *Gray Panthers*, *supra*, slip op. 2 & n.1. Under Section 1902(a)(17) of the Act, 42 U.S.C. (1970 ed.) 1396a(a)(17), each participating state was required to adopt "reasonable standards * * *

[1] Old Age Assistance, Title I, 42 U.S.C. (1970 ed.) 301 *et seq.*; Aid to Families with Dependent Children, Title IV, 42 U.S.C. (1970 ed.) 601 *et seq.*; Aid to the Blind, Title X, 42 U.S.C. (1970 ed.) 1201 *et seq.*; Aid to the Permanently and Totally Disabled, Title XIV, 42 U.S.C. (1970 ed.) 1351 *et seq.*

for determining eligibility for and the extent of medical assistance" and to take into account "only such income and resources as are * * * available to the applicant or recipient." Congress also required participating states to refrain from taking into account "the financial responsibility of any individual for any applicant or recipient of assistance * * * unless such applicant or recipient is such individual's spouse" or minor, blind, or disabled child. 42 U.S.C. (1970 ed.) 1396a(a)(17)(D); see *Schweiker* v. *Gray Panthers*, *supra*, slip op. 2.

With the approval of the Secretary of Health, Education, and Welfare (now Health and Human Services), some participating states took the position that it was reasonable to expect an applicant's spouse to help pay the cost of the applicant's medical expenses and, therefore, adopted rules that took into account the spouse's income in determining Medicaid eligibility and the amount of assistance. See *Schweiker* v. *Gray Panthers*, *supra*, slip op. 2-3 & n.2. These states calculated an amount considered necessary to pay the basic living expenses of the applicant's spouse and "deemed" any income of the spouse in excess of that amount to be "available" to the applicant. *Ibid.*

In 1972, Congress replaced three of the four categorical assistance programs with a new federal program, Supplemental Security Income for the Aged, Blind, and Disabled (SSI), 42 U.S.C. 1381 *et seq.*[2] See *Schweiker* v. *Gray Panthers*, *supra*, slip

[2] As its name indicates, the SSI program replaced the categorical assistance plans for the aged, blind, and disabled. The provisions of the old categorical assistance programs remain effective in Puerto Rico, Guam, and the Virgin Islands. See Pub. L. No. 92-603, Title III, Section 303(a) and (b), 86 Stat. 1484.

op. 3. As noted, from the inception of the Medicaid program in 1965, participating states were only required to provide medical assistance to those individuals receiving cash assistance under one of the categorical assistance programs. Participating states were also entitled to receive federal financial assistance under the Medicaid program if they chose to provide medical assistance to the "medically needy," *i.e.*, certain individuals who satisfied income requirements after incurred medical expenses were deducted from their income. See 42 U.S.C. (1970 ed.) 1396a (a)(10)(B). Adoption of the SSI program was not intended to affect the traditional linkage between categorical assistance eligibility and Medicaid eligibility. See 42 U.S.C. 1396a(a)(10)(A), (C), and 1396d(a); see also 42 U.S.C. 1383c.[3]

Under the SSI program, however, the states would no longer control the standards of need for the aged, blind, and disabled. In some states, the group of individuals that would be eligible for SSI assistance, and consequently eligible for Medicaid assistance, was significantly larger than the group of individuals that was eligible under the old assistance programs for the aged, blind, and disabled. See *Schweiker* v. *Gray Panthers*, *supra*, slip op. 3. Participating states would, therefore, have been forced to: (1) expand their Medicaid assistance obligations involuntarily, (2) withdraw from the Medicaid program, or (3) reduce the level of benefits provided under their Medicaid plans. To avoid these consequences, Congress

[3] Section 2171 of the Omnibus Budget Reconciliation Act of 1981 (Pub. L. No. 97-35, 95 Stat. 807) gives participating states more flexibility in extending Medicaid coverage to the "medically needy" than was permissible under 42 U.S.C. 1396a(a)(10)(B) and (C). It has no bearing on the issues in this case. See note 10, *infra*.

offered the states what has come to be called the "209(b) option," which allows each state either to accept the expanded Medicaid obligations resulting from adoption of the SSI program or to limit Medicaid eligibility to the group of individuals who would have been eligible for assistance under the state Medicaid plan in effect on January 1, 1972. 42 U.S.C. 1396a(f).[4] See *Schweiker* v. *Gray Panthers*, *supra*, slip op. 3-4.

The income of an applicant's spouse is attributed to the applicant for the purpose of determining eligibility and the amount of assistance under the SSI program. When the applicant and his spouse share a single home, the income of both is considered in determining the eligibility of either. 42 U.S.C. 1382(a), 1382c(b), (f)(1). If the applicant and his spouse cease to share the same household, the income of the applicant's spouse is considered only if the spouse is an "eligible spouse." 42 U.S.C. 1382c(b).[5] By definition, an applicant's spouse cannot remain an "eligible spouse" for more than six months after the separation. *Ibid.*

Any state that participates in the Medicaid program but fails to exercise the 209(b) option (an "SSI state") is specifically required to provide medical assistance to all SSI benefit recipients. 42 U.S.C. 1396a(a)(10)(A). The Secretary's regulations

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[4] The provision was enacted as Section 209(b) of the Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1381.

[5] For administrative reasons, if the applicant and his ineligible spouse separate in the middle of a particular month, the income of the spouse is considered for SSI purposes until the end of that month.

make explicit what is implicit in the relationship of the Medicaid and SSI statutes, by requiring all SSI states to consider the income of an applicant's spouse in making Medicaid determinations to the extent, but only to the extent, that the income would be considered under the SSI statute. 42 C.F.R. 435.723, 435.700. See *Schweiker* v. *Gray Panthers, supra*, slip op. 4-5.

2. Petitioners filed this class action in the United States District Court for the Southern District of Iowa, challenging the provisions of the Iowa Medicaid Plan that permit consideration of the income of an applicant's spouse. Iowa is an SSI state, but under its Medicaid program in effect at the time of suit a "formula" was used for determining the portion of the income of an applicant's spouse that was "available" to the applicant, apparently without regard to the length of time the applicant and his spouse had been separated (see Pet. App. 76-77a, 86a). Petitioners argued that the Iowa practice was inconsistent with both the requirements of Section 1902(a)(17) of the Act, 42 U.S.C. 1396a(a)(17), and the applicable HHS regulation, 42 C.F.R. 435.723 (Pet App. 79a).[6] Petitioners also argued that the Iowa procedures violated (i) the Equal Protection Clause of the Fourteenth Amendment because they irrationally discriminated against married institutionalized Medicaid applicants and (ii) the Due Process Clause of the Fourteenth Amendment because they created an "irrebutable presumption" that the spouse is able to pay the amount computed by the

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[6] At the time the complaint was filed, the applicable HHS regulation was codified at 45 C.F.R. 248.3(b) (1976).

formula and that the money is "actually available" to the applicant (Pet. App. 80a).[7]

Relying on Section 1902(a)(17), the district court held that Iowa could consider the income of an applicant's spouse in making Medicaid determinations, but only after making individualized factual inquiries to determine the amount of the spouse's income that should be attributed to the applicant. The court did not find that the amount of the income attributed to the named petitioner in this case was unreasonable or unduly burdensome: "the operation of the [Iowa] formula as finally computed appears to make a reasonable allocation of income in the situation before the Court"; but the court attributed that fact to "mere[] coinciden[ce]" (Pet App. 85a). According to the district court, Section 1902(a)(17) requires individual factual determinations in every case of what income is "available" (Pet. App. 85a). In addition, the district court concluded that the Iowa procedure was inconsistent with the HHS regulations (*id.* at 86a), but that the regulations themselves were inconsistent with the statute (*id.* at 87a). Because HHS was not a party to the litigation, the district court did not expressly hold the regulations invalid (*ibid.*).

In response to the district court's decision, Iowa adopted a procedure for making individual factual determinations of the amount of income of an applicant's spouse that is "available" for Medicaid

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[7] The district court's reference to the Due Process Clause of the Fifth Amendment (Pet. App. 80a) is erroneous. In any event, the district court did not reach the constitutional claims (Pet. App. 87a), apparently taking the position that its statutory holding eliminated the basis for petitioners' constitutional objections.

purposes. Petitioners objected and sought clarification of the district court's order, taking the position that none of the income of an applicant's spouse could be attributed to the applicant unless it was actually contributed (see Pet. App. 90a-91a). Applicable HHS regulations (which, as previously explained, reflect SSI income standards) require this result in an SSI state after the applicant and his spouse have been separated for one month if the applicant's spouse is not an "eligible spouse," as defined in 42 U.S.C. 1382c(b).[8] Nevertheless, the district court ignored the HHS regulations and "specifically approved" (Pet. App. 94a) the procedure adopted by Iowa. Although the court acknowledged that the position urged by petitioners "might be possible under the relevant statutes," it concluded that "[t]he existence of alternative procedures is irrelevant" (*id.* at 92a). The court also held that, in making Medicaid determinations, Iowa must disregard the receipt of Social Security benefits, Railroad Retirement Board annuities, and Civil Service Commission annuities (*id.* at 90a, 92a).

The court of appeals affirmed in part and reversed in part (Pet. App. 1a-75a). Sitting en banc, the Eighth Circuit affirmed by an equally divided court that part of the district court decision requiring Iowa to make individual factual determinations of available income for Medicaid purposes without regard to the time limitations imposed by the HHS regulations (*id.* at 2a). The court of appeals unanimously re-

[8] As noted above, no one can remain an "eligible spouse" for more than six months. Therefore, after an applicant and his spouse have been separated for more than six months, HHS regulations require the result contended for by petitioners in the district court.

versed the district court's holding that Iowa must disregard Social Security benefits, Railroad Retirement Board annuities, and Civil Service annuities in making Medicaid computations (*id.* at 2a, 28a, 74a).

SUMMARY OF ARGUMENT

The regulations of the Secretary of Health and Human Services governing the extent to which SSI states may consider the income of a Medicaid applicant's spouse as "available" to the applicant were adopted pursuant to explicit statutory authority. 42 U.S.C. 1396a(a)(17)(B). Those regulations therefore must be given "legislative effect," unless they are inconsistent with the Medicaid statute, arbitrary, or capricious. See *Schweiker* v. *Gray Panthers*, No. 80-756 (June 25, 1981), slip op. 9, quoting *Batterton* v. *Francis*, 432 U.S. 416, 425 (1977).

Nothing in the language or legislative history of the Medicaid Act *requires* the Secretary to permit participating states to consider the income of a Medicaid applicant's spouse as "available" to the applicant indefinitely and without limitation. Indeed, the legislative history of the Act indicates that Congress precluded the consideration of any person's income except that of the applicant, his spouse and, in some circumstances, his parent, and expressly authorized the Secretary to define the term "available" income precisely because it "was wary of imputing the income of others to a Medicaid applicant" (*Schweiker* v. *Gray Panthers*, *supra*, slip op. 12).

The Secretary's regulations are based on his sound analysis of the interlocking provisions of the Medicaid and SSI statutes. First, states that participate in the Medicaid program but fail to exercise the 209(b) option (*i.e.*, SSI states) are expressly required to

provide medical assistance to all recipients of SSI benefits. It follows, therefore, that SSI states cannot be permitted to consider income as "available" to an applicant for Medicaid purposes if that income would not be considered in determining SSI eligibility. Otherwise, contrary to the express requirements of 42 U.S.C. 1396a(a)(10)(A), SSI recipients could be denied Medicaid benefits. Second, with carefully limited exceptions, SSI states are not entitled to federal financial assistance for providing Medicaid benefits to individuals who are ineligible to receive SSI benefits, and, therefore, income must be considered "available" to a Medicaid applicant if it would be considered in determining SSI eligibility. Third, each of the pertinent exceptions to this general rule is defined in part by reference to the SSI standards of eligibility. The Secretary has therefore required participating states to consider the income of a Medicaid applicant's spouse as "available" to the applicant for purposes of determining coverage under these exceptions to the same extent that such income would be considered in determining SSI eligibility.

Thus, HHS regulations (42 C.F.R. 435.723, 435.700) requiring SSI states to consider the income of a Medicaid applicant's spouse as "available" to the applicant to the extent, but only to the extent, that such income would be considered in determining SSI eligibility are consistent with, and indeed virtually compelled by, the Medicaid statute, and are reasonable. Because the judgment of the court of appeals directs Iowa to ignore these regulations, it is erroneous and should be reversed.

ARGUMENT

THE SECRETARY'S REGULATIONS PRESCRIBING STANDARDS FOR DETERMINING "AVAILABLE" INCOME FOR PURPOSES OF MEDICAID ELIGIBILITY AND BENEFITS IN SSI JURISDICTIONS ARE VALID AND THEREFORE DISPOSITIVE IN THIS CASE

Congress explicitly delegated authority to the Secretary of Health and Human Services to prescribe controlling standards for calculating the income and resources of all Medicaid applicants. Under Section 1902(a)(17)(B) of the Social Security Act, all state Medicaid plans must include provisions for determining eligibility and the appropriate amount of assistance that take "into account only such income and resources as are, *as determined in accordance with standards prescribed by the Secretary*, available to the applicant or recipient * * *" (42 U.S.C. 1396a(a)(17)(B); emphasis added). Thus, unless the Secretary's definition of the term "available" income is inconsistent with the Medicaid Act, arbitrary, capricious, or otherwise invalid, the regulations are entitled to "legislative effect." See *Schweiker* v. *Gray Panthers*, No. 80-756 (June 25, 1981), slip op. 9. "In a situation of this kind, Congress entrusts to the Secretary, rather than to the courts, primary responsibility for interpreting the statutory term." *Batterton* v. *Francis*, 432 U.S. 416, 425 (1977); see also *Schweiker* v. *Gray Panthers*, *supra*, slip op. 9.

A. The Secretary's Regulations are Consistent with the Medicaid Act and Reasonable

1. Section 1902(a)(17) of the Social Security Act provides, in pertinent part, that a state Medicaid Plan must include:

> reasonable standards (which shall be comparable for all groups * * *) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account *only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available* to the applicant or recipient * * *, (C) provide for reasonable evaluation of any such income or resources, and (D) *do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child* * * *.

42 U.S.C. 1396a(a)(17) (emphasis added). As noted above, Congress specifically delegated authority to the Secretary to define the term "available" income as used in Subsection (B). Moreover, Subsection (D) makes it plain that Congress did not regard consideration of the income of an applicant's spouse as inconsistent with the "available" income limitation of Subsection (B). See *Schweiker* v. *Gray Panthers*, *supra*, slip op. 9-11; *Norman* v. *St. Clair*, 610 F.2d 1228, 1235-1237 (5th Cir. 1980), cert. denied *sub nom. Schweiker* v. *Norman*, No. 80-498 (July 2, 1981).

Nevertheless, "[i]t is clear beyond doubt that Congress was wary of imputing the income of others to a Medicaid applicant." *Schweiker* v. *Gray Panthers*, *supra*, slip op. 12. It is for precisely this reason that Congress flatly prohibited the consideration of the income of anyone other than the applicant and his spouse (or, in some circumstances, his parent) and expressly authorized the Secre-

tary to prescribe standards for determining the amount of income of these persons that is "available" to a Medicaid applicant. See H.R. Rep. No. 213, 89th Cong., 1st Sess. 67-68 (1965); S. Rep. No. 404, 89th Cong., 1st Sess. 78 (1965). Thus, except to the extent permitted by the Secretary, participating states may not consider the income of a Medicaid applicant's spouse as "available" to the applicant for purposes of determining eligibility and the amount of assistance.[9]

2. The Secretary's regulations require SSI states to consider the income of an applicant's spouse in making Medicaid determinations to the extent, but only to the extent, that such income would be considered in making eligibility and benefit determinations under the SSI statute. 42 C.F.R. 435.723, 435.700. See Pet. App. 55a-61a (McMillian, J., dissenting); pages 5-6, *supra*. The regulations are based upon the Secretary's analysis of the relationship between these two complex social welfare statutes. States that participate in the Medicaid program but fail to exercise the 209(b) option (42 U.S.C. 1396a(f)) must provide medical assistance to all individuals who are SSI recipients. 42 U.S.C. 1396a(a)(10)(A); 42 C.F.R. 435.120. It is evident, therefore, that as to this group SSI states cannot be permitted to consider the income of a Medicaid ap-

[9] Although recognizing that a participating state could consider the income of a Medicaid applicant's spouse (Pet. App. 83a-85a), the district court apparently concluded that the Secretary had no power to define the term "available" income so as to limit the extent to which a state could consider such income. As explained below (see pages 17-18), the district court's decision rests entirely on the erroneous conclusion that Congress' use of the term "available" income in Section 1902(a)(17)(B) of the Act requires individualized factual determinations.

plicant's spouse as "available" to the applicant if the income would not be considered in determining eligibility and the amount of assistance under the SSI statute. See 42 C.F.R. 435.700. Otherwise, an individual who is receiving SSI benefits might, nevertheless, be found ineligible for Medicaid benefits, contrary to the unequivocal command of 42 U.S.C. 1396a(a)(10)(A).

On the other hand, with carefully limited exceptions,[10] no SSI state is entitled to federal financial assistance for providing medical assistance to aged, blind, or disabled individuals who do not meet SSI income limitations. Unless the states are required to consider income as "available" to an applicant for purposes of determining Medicaid eligibility to the extent that it would be considered in determining SSI eligibility, it is impossible to distinguish those Medicaid applicants who are eligible for but not receiving SSI benefits from those who are simply ineligible for SSI benefits, without redetermining the eligibility of every non-SSI recipient covered in each state.

To the extent relevant here, SSI states may receive federal financial assistance for providing medical assistance to: (1) individuals who would be eligible for SSI benefits or an optional state supplement if

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[10] See, *e.g.*, 42 C.F.R. 435.122, 435.130, 435.131, 435.132, 435.133, 435.134, 435.135, 435.210, 435.211, 435.230, 435.231. Iowa does not have a "medically needy" program (which would permit it to cover certain individuals who do not meet SSI income limitations), and therefore it is unnecessary in this case to consider the regulations applicable to the "medically needy." See 42 C.F.R. 435.301. For the same reason, it is unnecessary to consider the consequences of the changes in the statutory provisions relevant to Medicaid coverage for the "medically needy" effected by the Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, Section 2171, 95 Stat. 807.

they applied, 42 C.F.R. 435.210;[11] and (2) individuals who would be eligible for SSI or an optional state supplement if they were not institutionalized and therefore subject to lower income standards, 42 C.F.R. 435.211; in addition, (3) if the state chooses to provide Medicaid coverage to the group that would be eligible for SSI or state supplementary payments but for institutionalization, then the state may also provide Medicaid assistance to the group of institutionalized individuals who would be ineligible for benefits under either the SSI program or the state supplement program even if they were not institutionalized, 42 C.F.R. 435.231.[12] Each of these groups is defined in part by reference to SSI income limitations. The Secretary quite reasonably, therefore, requires SSI states to use the same method for calculat-

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[11] Under Section 1616(a) of the Act, a state may make cash payments to certain individuals "as assistance based on need in supplementation of [SSI] benefits (as determined by the Secretary [of HHS])." 42 U.S.C. 1382e(a). Although the state may set higher income limitations than those applicable under the SSI statute, the state is only entitled to federal financial assistance for providing Medicaid coverage to these individuals if their gross income is no more than 300% of the SSI benefit amount (*i.e.*, 300% of the SSI income eligibility standard). See 42 U.S.C. 1396b(f)(4)(C); 42 C.F.R. 435.230, 435.1006. Furthermore, the state may only provide medical assistance to supplementary payment recipients who are receiving SSI benefits "or who would but for [excessive] income be eligible to receive such benefits." 42 U.S.C. 1396d(j).

[12] As observed above concerning Medicaid coverage of state supplementary payment recipients generally (note 11, *supra*), however, a participating state is entitled to federal financial assistance for providing medical assistance to a member of this group only if his gross income is not in excess of 300% of the SSI benefit amount. See 42 C.F.R. 435.231(a)(2), 435.1005.

ing income for purposes of Medicaid coverage under these exceptions as is used in determining SSI eligibility.[13]

Thus, HHS regulations (42 C.F.R. 435.723, 435.700) that require SSI states to consider the income of an applicant's spouse as "available" to the applicant for purposes of determining Medicaid eligibility to the same extent that it would be considered in determining SSI eligibility are not only reasonable; they are virtually "compelled by the relationship between the SSI and the Medicaid programs" (Pet. App. 61a-62a; McMillian, J., dissenting); see *Gray Panthers* v. *Administrator, Health Care Financing Administration*, 629 F.2d 180, 183 (D.C. Cir. 1980), rev'd on other grounds *sub nom. Schweiker* v. *Gray Panthers*, No. 80-756 (June 25, 1981); *Norman* v. *St. Clair*, *supra*, 610 F.2d at 1237-1238.

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[13] For example, if a state provides Medicaid coverage to individuals who would be eligible for state supplementary payments if they filed applications, it is entitled to federal financial assistance for providing medical assistance to an individual in this group only if his gross income does not exceed 300% of the SSI benefit amount. See 42 C.F.R. 435.210, 435.1006. If the state may ignore income (including that of the applicant's spouse) that would be considered in determining SSI eligibility, then the 300% limitation is rendered meaningless and the state may receive federal financial assistance for providing medical assistance to individuals whose income is greatly in excess of that limitation. On the other hand, if the state includes income that would be ignored under the SSI program, individuals who should be covered under this category will be improperly denied assistance. For example, an individual who would be eligible for SSI benefits if he applied is necessarily eligible for state supplementary payments. Yet, if the state, in determining Medicaid eligibility, may include income that is ignored for purposes of SSI, this individual may be denied medical assistance.

B. The "Deeming" Provisions of the Iowa Medicaid Plan Are Inconsistent with the Secretary's Regulations and Therefore Invalid

The district court's decision, which was upheld by an equally divided court of appeals, is plainly contrary to HHS regulations. In an SSI state such as Iowa, after the first month in which the applicant and his ineligible spouse have been separated, only income that is "actually contributed" to the applicant by his spouse may be considered "available" under the regulations. 42 C.F.R. 435.700, 435.723. Yet, the district court's order permits Iowa to consider the income of an applicant's spouse as "available" indefinitely, so long as the determination of available income is made after an individual factual hearing. As Judge Ross observed (Pet. App. 10a-11a), "there is no dispute that the new procedure approved by the district court is contrary to regulation [42 C.F.R.] 435.723." Respondents do not deny that their current procedure is contrary to HHS regulations; rather, they ignore the regulations and argue that the district court's interpretation of the statute is correct (see Br. in Opp. 15-16).

As we have shown above, however, the Secretary's "deeming regulation is based upon SSI eligibility criteria and is mandated by the Medicaid statute itself, which defines Medicaid eligibility by referring to SSI eligibility" (Pet. App. 37a; McMillian, J., dissenting). Moreover, the decision of the district court is based upon a single erroneous premise: namely, that Section 1902(a)(17) of the Act (42 U.S.C. 1396a(a)(17)) requires participating states to "provide for a factual determination in each instance of the amount of the spouse's income which is in fact reasonably available for the support of the institutionalized [Medicaid applicant]" (Pet. App.

85a). According to the district court (*id.* at 87a), "'deeming' is contrary to congressional intent whether income of the noninstitutionalized spouse is deemed available or unavailable." See also *id.* at 92a. In *Schweiker* v. *Gray Panthers*, *supra*, slip op. 12-15, however, this Court expressly rejected the contention that individualized determinations of "available" income are required in each case.

There is nothing in the plain language of Section 1902(a)(17) of the Act or its legislative history that can support the holding of the district court. While the statute reflects Congress' determination that it might be reasonable to permit the states to consider the income of a Medicaid applicant's spouse under some circumstances, it is equally plain that Congress delegated "exceptionally broad authority" (*Schweiker* v. *Gray Panthers*, *supra*, slip op. 8) to the Secretary for defining those circumstances. The Secretary has exercised that authority, and Section 1902(a)(17) cannot be read to permit participating states to ignore the standards for determining available income that it specifically authorizes the Secretary to prescribe. Nor is "[a] reviewing court free to set aside" or disregard such an exercise of authority "simply because it would have interpreted the statute in a different manner." *Batterton* v. *Francis*, *supra*, 432 U.S. at 425.

The decision in this case also seriously misapprehends the relationship between the Medicaid and SSI statutes. Having failed to exercise the 209(b) option, Iowa is statutorily required to provide Medicaid coverage to *all* SSI recipients. 42 U.S.C. 1396a(a)(10)(A); 42 C.F.R. 435.120. The income of an applicant's ineligible spouse is not considered for purposes of determining SSI eligibility after an applicant has been institutionalized for one month. See 42 U.S.C.

1382(a)(1), 1382c(b), (f)(1); 42 C.F.R. 435.723 (d). Hence, as explained above and as the Secretary's regulations provide, such income may not be considered beyond the one-month period in determining eligibility for or the amount of Medicaid benefits.

If, as in the named petitioner's case, the applicant has no income of his own and is in a private institution, he is eligible for SSI benefits. If such an applicant applies for and receives SSI benefits, then in an SSI state he would also be entitled to Medicaid benefits under the express terms of the Medicaid Act. Yet, under the district court's order, Iowa may deny Medicaid benefits to such an applicant if, after making an individual factual determination, Iowa concludes that the income of the spouse should be considered available even though it was not actually contributed and hence was not considered in determining the applicant's eligibility for SSI benefits.[14]

The district court certified a class in this case comprised of (Pet. App. 87a):

> all married couples residing in Iowa of which: (1) one spouse is eligible for Medicaid and requires institutionalization; and (2) the other spouse is not institutionalized; and (3) the non-institutionalized spouse has income which is, under current state procedures, being deemed available to the institutionalized spouse.

That class is on its face not limited to non-SSI recipients. Furthermore, the new Iowa deeming procedure,

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[14] Petitioner Elvina Herweg is not an SSI recipient, but the same analysis is appropriate with respect to an individual who would be eligible if he applied (42 C.F.R. 435.210, 435.723) or would be eligible but for his institutionalization (42 C.F.R. 435.211, 435.723), assuming, of course, that the state chooses to cover these groups, as Iowa has (see 3 Medicare & Medicaid Guide (CCH) ¶ 15,586, at 6543 (July 23, 1980)).

which was specifically approved by the district court, is by its terms applicable "to all applicants/recipients in a Title XIX Medical Institution who: 1. Have a non-institutionalized spouse * * * and 2. The non-institutionalized spouse * * * [is] ineligible for SSI * * *." [15] Thus, the district court's decision allows Iowa to adopt procedures that violate both the Secretary's regulations and the explicit command of Section 1902(a)(10)(A) of the Act, 42 U.S.C. 1396(a)(10)(A). This decision should be reversed.

CONCLUSION

The judgment of the court of appeals affirming the judgment of the district court should be reversed.

Respectfully submitted.

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[15] State of Iowa, Department of Social Services, Des Moines, Social Services Manual Letter No. 37, at 1-2 (Aug. 8, 1978). See also *id.* at 8 (contemplating application of the new procedure to SSI recipients).

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